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Message from the President

It Takes All of Us to Protect the Public

Roxanne McDaniel, PhD, RN, President

The Board of Nursing's executive director, Lori Scheidt, was fortunate to attend the first Tri-Regulator Symposium held Oct. 17-18th in Washington, D.C. The theme of the symposium was *"Protecting Patients and the Public: A Heritage of Excellence,"* and was hosted by the Federation of State Medical Boards (FSMB), the National Association of Boards of Pharmacy (NABP), and the National Council of State Boards of Nursing (NCSBN). The meeting reinforced the fact that regulatory issues among medical, pharmacy and nursing licensing boards are more similar than not. More importantly it became very clear how important it is for health care licensing boards to collaborate. The Keynote Speaker Donna Shalala, former Secretary of Health and Human Services under President Clinton, made this very point. Dr. Shalala's primary message was that state licensing boards must collaborate because of the impact that licensing boards have in promoting and advancing the health of the nation.

Interprofessional education panels presented current regulatory challenges on issues regarding opioid prescription abuse, the future of state-based regulation, assessment of professional competency, and health care workforce data needs of the country. All three health care licensing boards shared common challenges with other issues such as discipline and complaint resolution, budget challenges, fraudulent documents, re-entry into practice, public member involvement, and ongoing board governance education.

I am delighted that we are going to start collaboration with our health regulatory boards at a state level. Our initial health regulatory boards meeting has been scheduled with the board of nursing, board of pharmacy, board of registration for the healing arts and dental board.

We look forward to collaborating with our health regulator colleagues at the state level. Healthcare licensing boards are key strategic partners that collectively impact patient protection and patient safety.

Missouri Board of Pharmacy MoSafeRx Initiative

The Missouri Board of Pharmacy announced the launch of its 2013 patient safety initiative *"MoSafeRx."* The goal of their initiative is to encourage and promote a culture of patient safety in pharmacy practice throughout Missouri. Pharmacists are trusted and valuable members of the healthcare team and play a vital role in providing safe patient care. By utilizing effective patient safety tools and strategies, we can help ensure *"Safe Practice, Safe Patients and a Safe Missouri."* I urge you to visit their web site to learn how you can help ensure *"safe practice, safe patients and a safe Missouri."* http://pr.mo.gov/pharmacists.asp

Executive Director's Report

Authored by Lori Scheidt, Executive Director

Legislative Update

Our newsletter articles are due approximately two months before the newsletter is actually published. By the time you receive this newsletter the legislative session will have ended. In order to determine if bills actually passed, you can check the final disposition of bills at *http://moga.mo.gov/*

Missouri Nursing Practice Act

Senator Jay Wasson (R-District 20) filed Senate Bill 370. Passage of this bill would add additional causes for which the Board of Nursing may file a complaint and allows the Board to request an emergency suspension of a license.

Advanced Practice Registered Nurse Practice Bills

Senator David Sater (R-District 29) filed Senate Bill 167. Representative Lyle Rowland (R-District 155) filed House Bill 314. Passage of either of these bills would modify the laws relating to advanced practice registered nurses and collaborative practice arrangements.

APRN Waiver of Collaborative Practice Mileage Requirement for Rural Health Clinics Only

Senator Jay Wasson (R-District 20) filed Senate Bill 330 and Representative Eric Burlison (R-District 133) filed House Bill 625. Passage of either of these would allow the geographic proximity to be waived for a maximum of 28 days per calendar year for rural health clinics as long as the collaborative practice arrangement includes alternative plans for coverage.

Social Security Numbers on License Renewals

Senator Scott Sifton (D-District 1) filed Senate Bill 289–and Senator Wayne Wallingford (R-District 27) filed Senate Bill 314. Passage of either of these bills would change the Social Security number requirement. Under current law, every application for a renewal of a professional license, certificate, registration, or permit must contain the applicant's Social Security number. This act states that an application for a professional license renewal only has to include a Social Security number in situations where the original application did not contain a Social Security number. After the initial application for license renewal which includes a Social Security number, an applicant is no longer required to provide a Social Security number in subsequent renewal applications.

Military Credit

Senator Dan Brown (R-District 16) filed Senate Bill 106 and Representative Charlie Davis (R-District 162)

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Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

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filed House Bill 114. Passage of either of these bills would require all boards within the Division of Professional Registration to promulgate rules by January 1, 2014. Upon presentation of satisfactory evidence by an applicant for certification or licensure, the appropriate board shall accept education, training, or service completed by an individual who is a member of the United States armed forces or reserves, the national guard of any state, the military reserves of any state, or the naval militia of any state toward the qualifications to receive the license or certification.

Malpractice Insurance Proof for Homebirth Services

Representative Caleb Jones (R-District 50) filed House Bill 308. Passage of this bill would require that any person certified and providing home birth services shall, prior to the provision of such services, furnish to all individuals for whom such services will be provided satisfactory evidence that such person has obtained and maintains a midwifery malpractice insurance policy with coverage of at least one million dollars. Any person who fails, prior to the provision of such services, to present proof of such malpractice insurance coverage is guilty of a class C misdemeanor.

Board of Professional Midwives

Representative Kurt Bahr (R-District 102) filed House Bill 514. Passage of this bill would create a "Board of Professional Midwives" within the Division of Professional Registration. This would be a six member board with five professional midwives and one public member. A professional midwife is defined as a person who is certified by the North American Registry of Midwives (NARM) as a certified professional midwife (CPM) and provides for compensation those skills relevant to the care of women and infants in the antepartum, intrapartum, and postpartum period. It would give the board similar powers as other boards: issue licenses, renew licenses, deny licenses, conduct investigations, etc.

Influenza Vaccination Requirement

Representative Jill Schupp (D-District 088) filed House Bill 792. Passage of this bill would require every employee and volunteer of a health care facility inspected by the department of health and senior services to receive an influenza vaccination each year.

Your Role in the Legislative Process

Legislation impacts nursing careers, shapes health care policy and influences the care delivered to patients. Your education, expertise, and well-earned public respect as a nurse can allow you to exert considerable influence on health care policy. Nurses have been somewhat reluctant to do this in the past but you are in an excellent position to advocate for patients. Never underestimate the importance of what you have to say. As a professional, you bring a unique perspective to health care issues and often have intricate knowledge that helps provide insight for our legislators.

You should make your thoughts known to your legislative representatives. You can meet with, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at http://moga.mo.gov/

Number of Nurses Currently Licensed in the State of Missouri

As of April 18, 2013

Profession	Number
Licensed Practical Nurse	24,142
Registered Professional Nurse	96,884
Total	**121,026**

http://pr.mo.gov

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Education Report

Statistics on Pre-licensure Nursing Education in Missouri

Authored by Bibi Schultz, RN MSN, CNE
Education Administrator

Missouri State Board of Nursing (MSBN) Education Committee Members:

- Roxanne McDaniel, RN, PhD (Chair)
- Lisa Green, RN, PhD(c)
- Irene Coco-Bell, LPN

Official NCLEX nursing licensure exam data is released in January of each year. Pursuant to Missouri State Board of Nursing rules for nursing programs, a minimum annual first-time tester pass rate of 80% is required. It is significant to note how well Missouri nursing programs prepare their graduates for the licensure exam. While nurse educators across the state continue to develop and utilize innovative ways to teach their students, standards for nursing education are deeply grounded in pedagogical concepts and reflect strong focus on patient safety and transition to nursing practice. Ongoing efforts to keep curricular content current and clinical learning reflective of today's comprehensive clinical environment greatly contribute to this success. When compared with national licensure exam statistics, Missouri graduates exceed national pass rates by steadily widening margins, as indicated in the table below.

NCLEX LICENSURE EXAM STATISTICS

Year	Type of Program	Missouri Average Pass Rate	National Average Pass Rate
2008	Registered Nursing	87.85%	86.73%
	Practical Nursing	89.86%	85.62%
2009	Registered Nursing	90.02%	88.42%
	Practical Nursing	89.39%	85.73%
2010	Registered Nursing	88.42%	87.42%
	Practical Nursing	92.33%	87.06%
2011	Registered Nursing	90.16%	87.90%
	Practical Nursing	92.43%	84.84%
2012	Registered Nursing	93.43%	90.34%
	Practical Nursing	92.55%	84.23%

National NCLEX statistics indicate that in 2012 a total of 4,977 Missouri graduates took their nursing licensure exam for the first time; of those 4,638 passed the exam on the first attempt. Within this data, out of 3,608 first-time testers for RN licensure 3,371 passed the exam on the first attempt. For LPN licensure, out of 1,369 first-time testers 1,267 passed the exam on the first attempt. It should be noted that each year the number of Missouri graduates sitting for the RN licensure exam has increased (3,416 in 2011 to 3,608 in 2012); whereas data reflects a slight decrease in Practical Nurse graduates sitting for the licensure exam for the first-time (1,454 in 2011 to 1,369 in 2012).

While local statistics regarding Missouri nursing programs are collected in a number of ways, annual reporting provides a rather comprehensive look at pre-licensure program data. Annual reporting for 2011 indicates that Missouri pre-licensure nursing programs have turned away 3,780 (BSN programs = 1,369, ADN programs = 1,585, PN programs = 826) applicants deemed eligible for admission but who could not be accommodated at that time. It is important to note that report data may be somewhat skewed since applicants often simultaneously apply to more than one nursing program/site. An applicant may also be deemed eligible for admission, even though he or she may not completely meet admission requirements at the time of application and therefore would not be eligible to enter the program as planned. With that said, when compared with the number of first-time testers in 2012, the number of applicants that were reported to have been turned away in 2011 becomes even more significant.

A variety of factors impacts the number of admissions to nursing programs. Ongoing struggles to secure qualified faculty and availability of appropriate clinical placements are among major challenges. Annual reporting data indicates that in 2011 programs would have needed 290 additional faculty members to accommodate all prelicensure applicants who were deemed qualified for admission. While Associate Degree in Nursing programs report the highest numbers of applicants that could not be admitted (1,585), Baccalaureate Degree in Nursing programs report the greatest need for additional faculty (141) to accommodate all applicants. As mentioned in an earlier article, data collection from 2010 annual reporting predicts additional impact on faculty resources within the next couple of years. In 2010 nursing programs indicated that at least 142 nursing faculty were planning to retire by 2015.

Significant change in the approach to nursing education is essential. A committee charged by the Missouri Action Coalition – Future of Nursing has been working for the

Statistics on Pre-licensure Nursing continued on page 4

Missouri Nursing Education Resource Committee – Call to Action

In October 2012 the Missouri State Board of Nursing accepted development of a set of nursing education resources to be made available to nurse educators across the state as one of the Board's initiatives for 2013. To facilitate development of this set of resources, forming of the Missouri Nursing Education Resource Committee (MONERC) has been initiated. Several nurse educators have expressed interest in serving on this committee. The MONERC committee will convene to determine/apply best practices for nursing education and to provide expert examples/templates to guide educational as well as self-evaluation processes for nursing programs in Missouri. Utilization of sample resources will be strictly voluntary and in no way mandated by the Board. Resources will be made available to nurse educators as examples to assist with often tedious design of program documents and templates. Potential resources may include sample meeting minutes, sample faculty orientation plans, sample faculty mentoring records, generic library policies, a sample plan for acquisition and maintenance for skills lab equipment and supplies, and a sample plan for systematic program evaluation, just to name a few.

Nurse educators from all levels of nursing education across the state are invited to take part in this committee. Meetings will take place about every other month; some meetings will be conducted on a face-to-face basis, and some by conference call to facilitate committee processes. **Projected beginning of the committee's work is spring 2013; please express your interest to serve on this committee to Bibi Schultz at bibi.schultz@pr.mo.gov.**

Statistics on Pre-licensure Nursing continued from page 3

last year to revise the Missouri Articulation Plan (MAP). Differentiated essential competencies, derived from competencies developed by the Texas Board of Nursing and utilized with their permission, are specific to each level of pre-licensure nursing education in Missouri. It is essential for nurse educators to become familiar with the MAP, evaluate their own graduate competencies, objectives and curricular content and make every effort for their nursing program to become a signatory to the MAP. While participation in the MAP is voluntary, it certainly helps pave the way for Missouri graduates and nurses to more seamlessly progress to BSN completion, receive deserved transfer credit for prior formal learning and conserve valuable educational resources. Renewed focus on partnerships between programs at all levels of nursing education is a must in this time of limited resources. Innovative sharing of faculty and their expertise, alignment of curricula designed for seamless progression, and collective utilization of often costly instructional resources are just the beginning. While it is essential to continue measures to increase access to nursing education, it is equally important to ensure that quality in nursing education and therefore patient safety is continuously monitored and maintained. Collaboration in academic as well as clinical settings brings about awareness of what others are doing, opens the door to resolution of barriers and promises to brighten the future of nursing education and practice.

Practice Corner

Authored by Debra Funk, RN
Practice Administrator

A Reminder to APRNs

I recently received an email from a pharmacist on the west side of the state with a concern regarding the information required to be on a prescription from an APRN. He reported that his pharmacy had been receiving many prescriptions from APRNs without the collaborating physician's name, address and telephone number. Due to the prescription not meeting the requirements of state regulations, many patients are not receiving their medication in a timely fashion.

Pursuant to 20 CSR 2200-4.200 (3)(G)7, "All prescriptions shall conform to all applicable state and federal statutes, rules or regulations and shall include the name, address and telephone number of the collaborating physician and collaborating APRN."

This information should be printed on all prescription forms. The pharmacist was informed that there are many new E-script/EMRs out there that do not permit some of this information to be included with the prescription. Unfortunately, the rules were written prior to the evolution of the electronic medical record.

U.S. RNs Encouraged to Contribute to National Workforce Research

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Chicago – The National Council of State Boards of Nursing (NCSBN) and the Forum of State Nursing Workforce Centers will conduct a national survey of registered nurses (RNs) beginning in January 2013.

All RNs in the U.S. with active RN licenses are eligible candidates for survey participation. A random sample of this population will be chosen to participate. Nurses who receive the survey are strongly encouraged to provide information such as basic demographic and professional data (e.g., age, year licensed, etc.) even if they are now employed in another profession or are retired. All responses will be kept confidential and data will only be reported in the aggregate.

The results of this survey are especially valuable in light of several factors. One is that no national source of current, complete and consistent information for nursing workforce data exists and this survey has the potential to fill that void. Also, the implementation of the Patient Protection and Affordable Care Act will insure more than 30 million U.S. residents who will seek health care in the years ahead. Additionally, the aging U.S. population means there will be an increased demand for nursing services in coming years. It is possible that the predicted shortfall of qualified nurses to care for this population will occur and will have a major impact on health care delivery in the future.

An adequate supply of RNs in the workforce is one of the essential components of a safe and effective health care system. Information from RNs selected to respond to this survey have a unique chance to contribute to this invaluable study, the results of which can be used to predict possible shortages and assist in the allocation of resources, program development decisions, and recruitment efforts in both the health care system and education sectors.

About NCSBN

The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories – American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also 12 associate members. Mission: NCSBN provides education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. The statements and opinions expressed are those of NCSBN and not the individual member state or territorial boards of nursing.

About Forum of State Nursing Workforce Centers

The Forum of State Nursing Workforce Centers is a national group of nurse workforce entities that focus on addressing the nursing shortage within each state and contributes to the national effort to assure an adequate supply of qualified nurses to meet the health needs of the US population. The Forum supports the advancement of new as well as existing nurse workforce initiatives and shares best practices in nursing workforce research, workforce planning, workforce development, and formulation of workforce policy. We share information in three major ways: through publications, via annual conferences, and by way of a virtual network.

Nursys® e-Notify – an Innovative Nurse Notification System

Every year, boards of nursing (BONs) across the U.S. contact thousands of their nurses to remind them to renew their nursing license. Some BONs send emails; others send postcards and letters. It is then the responsibility of the nurse to renew their license. Left out of this equation, however, are the employers who rely on nurses to have current licenses to practice. Previously, the only way for employers to know if a nurse's license was about to expire was to look it up, one nurse at a time. And when it came to learning about discipline status, employers were left out of the loop again, having to seek this information on their own.

Not anymore.

Institutions that employ nurses can now receive automatic licensure and discipline notifications about their nurses quickly, easily and securely with NCSBN's new Nursys® e-Notify system. e-Notify is an innovative nurse licensure notification system that automatically provides employers licensure and publicly available discipline data as it is entered into Nursys by BONs. Employers will no longer have to proactively seek licensure or discipline information of nurses in their employ; that information will automatically be sent to them.

The e-Notify system alerts subscribers when changes are made to a nurse's record, including changes to license status, license expirations, license renewal, and public disciplinary action/resolutions and alerts. This means that if a nurse's license is about to expire, the system will send a notification to the employer about the expiration date. Employers can also immediately learn about new disciplinary actions issued by a BON for their employed nurse, including receiving access to available public discipline documents.

Benefits

The information in e-Notify is pulled directly from Nursys, the only national database for licensure verification, discipline and practice privileges for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs). Nursys data is compiled from information directly inputted from BONs (in participating jurisdictions; visit nursys.com for current participation list). The system provides real-time automatic notification of status and discipline changes delivered directly to institutions.

Cost

All institutions are given 100 credits free of charge. This means that the first 100 nurses enrolled into the system are free. After that, each nurse is $1 per nurse, per year. A facility that employs 25 nurses would pay nothing to utilize e-Notify; a facility with 150 nurses would only pay $50 per year.

A unique feature of e-Notify is the ability for institutions to turn a nurse's notification setting on or off, choosing whether or not to receive notifications about a specific nurse's licensure or discipline status. Only nurses who have their notifications turned on are charged against one of the employer's 100 free credits.

Customizable Features

It's entirely up to the institution to determine how often they want to receive notifications about their nurses. They have the option of receiving email notifications daily, weekly or monthly. For licensure renewal notifications, institutions can choose to receive alerts 30, 60 or 90 days prior to a nurse's license expiring.

Ease of Use

Institutions can enroll nurses into e-Notify easily either as an individual or through bulk upload; all that is needed is the nurse's license number, license type and the state that issued their license. This information is used to locate the nurse directly from the Nursys database. Once nurses are enrolled, institutions can access their nurse list and download the data at anytime.

Another unique feature of e-Notify is its search functionality. Rather than searching for a nurse by his or her name, e-Notify only allows institutions to search by licensure number. This way, if a nurse changes their name with the BON, that information will automatically be updated in e-Notify, decreasing the likelihood of multiple entries being entered into the system for the same person.

When enrolling a nurse in e-Notify, institutions also have the option of including the nurse's email address and/or cell phone number. Institutions can send automatic e-mail reminders, as well as text messages, to nurses securely.

With e-Notify, any institution that employs a nurse can utilize this system to track licensure and discipline information for little or no charge. e-Notify is an innovative tool that provides vital information to employers, saving them money and staff time.

To subscribe to Nursys e-Notify go to nursys.com.

Navigating the Nurse Licensure Compact: Initial Licensure by Examination for New Graduates

Determine your primary state of residence (PSOR): Answer the following questions,
1) In which state do you hold a drivers license?
2) In which state are you registered to vote?
3) In which state do you file your federal income tax?

Is your primary state a member of the NLC?

YES → **Multi-State License** Apply for initial licensure by examination in your primary state of residence (PSOR).

NO → **Single-State License** You may apply for an initial license by examination in any **one** state of choice.

Follow the eight steps of the NCLEX

1. Apply for licensure with ONE board of nursing (BON).
2. Register and pay $200 with Pearson VUE (see candidate bulletin).
3. Receive receipt of registration from Pearson VUE.
4. Receive eligibility from the BON.
5. Receive an authorization to test (ATT) via letter or email from Pearson VUE.
6. Schedule an exam with Pearson VUE via the internet or phone.
7. Arrive for exam, present ATT letter and ID (see candidate bulletin).
8. Receive results from the BON.

Your new multi-state license grants a privilege to practice in all NLC states contingent upon remaining a resident of the issuing state.

Each single-state license is valid for practice only in the state of issuance.

Navigating the Nurse Licensure Compact: Licensure by Endorsement

Declaring a New Primary State of Residence (PSOR) / Obtaining a License when Moving from One State to Another

Is your new primary state of residence part of the Nurse Licensure Compact?

YES →
- Apply for a RN or LPN license in your new primary state of residence.
- You may continue to practice for up to 30 days from the time you establish residency, on your privilege to practice from your former home state / PSOR.
- You can only hold one multi-state RN or LPN license but may hold multiple non-compact state licenses.
- Your former license will be inactivated upon receipt of new home state license.
- Your new multi-state license grants a privilege to practice in all NLC states contingent upon remaining a resident of the issuing state.

No →
- Apply for licensure in that state.
- You may not practice in a non-compact state until you have a temporary permit or permanent license.
- You may hold multiple licenses from non compact states.
- Each single-state license is valid for practice only in the state of issuance.

Innovations in Nursing Education: The State of the Art

Teri A. Murray, PhD, APHN-BC, RN, FAAN

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Dr. Murray was a member of the Missouri State Board of Nursing from 2001 to 2009. She served as Secretary, President and on several national committees during her term on the Board.

This article provides an overview of the innovative pedagogic practices in nursing education published between 2009 and 2012. Four distinct categories emerged from the literature review: calls to action for reform or educational redesign; the use of technology; partnerships; and innovative curricular, clinical, and classroom teaching strategies. The publications provide clear evidence of the high capacity for creativity and innovation in nursing education.

The continuing current and future demand for nurses translates into the need for education programs that can prepare nurses effectively. Increasing calls for innovation have prompted many educational institutions to develop programs that meet education needs in new ways. The purpose of this article is to review innovations that have occurred from 2009 to 2012.

Effect of Nurse Demand on Education

The demand for registered nurses (RNs) remains at an all-time high despite the worst economic era since the Great Depression. Throughout the next decade, the number of employed RNs is expected to increase by 26%, with an anticipated need for 250,000 to 1 million new or replacement nurses (U.S. Department of Labor, Bureau of Labor Statistics, 2012a). This demand can be attributed to advances in medical and health care technology; a greater emphasis on preventive care, which increases longevity; an aging population that requires more health care services; and an aging nursing workforce nearing retirement (U.S. Department of Labor, Bureau of Labor Statistics, 2012b).

Despite this projected need, more than 75,000 qualified applicants were unable to pursue nursing as a profession (American Association of Colleges of Nursing [AACN], 2012). The majority of schools could not admit all qualified applicants into nursing programs because of institutional, clinical environment, human resource, and budgetary constraints. Limitations included:

- classroom space for large numbers of students
- clinical placement sites for clinical practice
- clinical preceptors for student nurses
- fiscal resources to hire more nurse educators
- nurse faculty.

Less than 4% of the nearly 3 million RNs seek the graduate education required to work as a nurse educator (AACN, 2011). All these constraints cripple the profession's ability to produce more RNs, thereby reinforcing the existing shortage and intensifying future shortages (AACN, 2012).

Need for Innovation

The concerns about limited capacity in nursing education have spurred questions about the sustainability of the current educational model and served as a catalyst for calls, position statements, and consensus documents from national leaders, professional associations, foundations, and government agencies for reform and innovation. *Innovation* is defined as a process for inventing something new or improving on existing practices (Blakeney, Carleton, McCarthy, & Coakley, 2009; Christensen, Bohmer, & Kenagy, 2000). Research is needed to determine the best practices in nursing education, so the risks of innovation are reduced while the benefits are reaped (Ferguson & Day, 2005). Without an adequate research base, best practices can be elusive, undefined, and anecdotal. In the absence of credible evidence, educators will use their judgment about the most effective approaches, often based on traditional or innovative but untested methods (Ferguson & Day, 2005).

The Robert Wood Johnson Foundation, the Center to Champion Nursing in America, and the U.S. Department of Labor, Employment, and Training Administration commissioned the White Paper, *Blowing Open the Bottleneck,* to encourage nurse leaders to rethink how nurses are and should be educated (Joynt & Kimball, 2008). The National League for Nursing urged "bold new thinking and action in the pedagogic approaches to nursing education" (National League for Nursing, 2003, p. 1). The Carnegie National Nurses Education Study recommended radical changes to the current educational system (Benner, Sutphen, Leonard, & Day, 2010). The Robert Wood Johnson Foundation and the Institute of Medicine Committee in its landmark report, *The Future of Nursing: Leading Change, Advancing Health,* recommended a transformed nursing education system that includes continued lifelong learning, seamless transition to higher degree programs, a diverse workforce, and opportunities for interprofessional education and practice (Institute of Medicine, 2011).

Even with these urgent calls for reform and transformation, the academic community has been slow to change its pedagogic approaches. The majority of nursing programs are deeply entrenched in the status quo of lecture and small-group clinical education with faculty oversight. Many are firmly committed to this traditional approach and hesitant to try new or innovative practices. Perhaps the reluctance to depart from time-honored practices is perpetuated by the limited amount of research specific to the pedagogy of nursing education. The nearly 3 million practicing U.S. nurses attest to the success of the nursing academy in educating nurses. "Oftentimes the more successful a practice or method becomes the more difficult it is to recognize the need for change. Successful practices can create distinct traditions and ideologies that lead to orthodoxies which are rarely challenged and frequently limit agility and innovation" (Prahalad, 2010, p. 36).

Boards of nursing (BONs) have often been viewed as impediments to innovation and sometimes used as the reason to stave off innovation. In 2009 as a response to this perception and with the desire to advance innovation in regulation, the National Council of State Boards of Nursing established the Innovations in Education Regulation Committee, which had three primary purposes: foster innovative models of nursing education, ensure educational innovations are consistent with public protection, and ensure the proposed innovative approaches contain the core educational criteria to result in quality outcomes. The committee comprised individual state BON members or board staff representing nine states. Its work culminated in the development of *Model Rules for Innovative Approaches in Nursing Education Programs*, which can be adopted by BONs to advance innovative educational approaches (National Council of State Boards of Nursing, 2009).

These myriad activities made this an ideal time to review innovations in nursing education.

Review of Published Innovations in Nursing Education

The review described here examines the educational innovations in prelicensure education in U.S. nursing programs between 2009 and 2012. The criteria for inclusion in this review were peer-reviewed articles published in U.S. journals; the journal articles had to address a U.S. prelicensure program; and the innovation had to focus on classroom or clinical activity. A database search and review by the author revealed 106 articles that met the inclusion criteria.

The following major categories emerged from the literature review:

- Calls to action for reform or educational redesign
- Use of technology
- Partnerships
- Innovative curricular, clinical, and classroom teaching strategies

Calls to Action

Several articles reinforce, validate, and further substantiate earlier calls for reformation of prelicensure nursing education. The calls center on the need to reexamine nursing education through the lens of innovative possibilities and consider alternatives to the traditional pedagogies (Niederhauser, MacIntyre, Garner, Teel, & Murray, 2010). Some suggest the need to implement cutting-edge strategies to expand educational capacity (Malloch & Porter-O'Grady, 2011), to develop institutional cultures that support innovation (Melnyk & Davidson, 2010), and to reevaluate the current practices and develop new models of teaching and clinical care (Glasgow, Niederhauser, Dunphy, & Mainous, 2010; MacIntyre, Murray, Teel, & Karshmer, 2009).

Use of Technology

The use of various technologies as innovative pedagogic approaches has become increasingly popular in nursing education. These technologies are believed to enhance and strengthen the educational process and balance the challenges associated with the faculty shortage and limited classroom and clinical space.

Since 2009, simulation in undergraduate nursing education has incorporated a variety of techniques, including the use of role play, standardized patients, interactive media, and low- and high-fidelity mannequins (Ironside, Jeffries, & Martin, 2009), though the majority of the publications focus on simulation using high-fidelity mannequins. Descriptions for using simulation included teaching specific content, such as patient safety, pediatric codes, and decision making in specific clinical scenarios, as well as teaching competencies associated with interprofessional and collaborative practice using a variety of health care professionals (Henneman et al., 2010; Ironside et al., 2009; Kaplan, Holmes, Mott, & Atallah, 2011; Robertson et al., 2010).

Virtual reality simulation (VRS) is used to allow students to engage in real-life experiences in low-risk environments. "VRS is a computer-assisted program that enables images and objects to appear as real. The projection of three-dimensional views and the use of stereo images provided a sense of presence thus creating the sense of being in the simulated environment" (Jensen & Forsyth, 2012, p. 313). This innovative approach had been used to offset the challenges associated with increased patient acuity, high student-to-faculty instructional ratios, patient safety, and student anxiety (Jenson & Forsyth, 2012). Second Life multiuser virtual environment (MUVE) is described as an Internet-based simulated environment in which the participant is represented by an avatar that can move freely through the environment manipulating objects (Schmidt & Stewart, 2009). Trangenstein, Weiner, Gordon, and McNew (2010) describe Second Life as a MUVE that uses a three-dimensional modeling feature to replicate real world settings and experiences (p. 644). Second Life is touted as providing the student with experiential learning and construction of knowledge in a low-risk, safe simulated environment (Skiba, 2007). The MUVE allows multiple users to interact and communicate with one another in a virtual world (Schmidt & Stewart, 2009).

Another innovative use of technology-mediated instruction in the literature is the virtual clinical practicum (VCP). This technology enables students to interact in real time with patients and preceptors in a geographically distant clinical environment. The VCP is a telehealth clinical practicum whereby students observe all activity in the patient's room virtually while receiving clinical instruction from the nurse preceptor at the bedside; the instruction is reinforced by the course faculty at the college (Grady, 2011). The major drawback described is that VCP provided limited hands on and person-to-person experience with the patient (Grady, 2011).

Other technology in the literature includes the use of personal digital assistants (PDAs) by students for classroom and clinical activities (Cibulka & Crane-Wider, 2011; George, Davidson, Serapiglia, Barla, & Thotakura, 2010). The students use the mobile device to access and manage clinically relevant information. The PDA provides point-of-care access to information and just-in-time learning. This immediate access to information is believed to improve the student's ability to provide sound, effective, quality patient care.

Distance education (online or Web-delivered) course work is another emerging innovative practice for prelicensure education used to increase student access to higher education, particularly in rural areas, and to expand student and faculty capacity. Although online education for graduate nursing education has been in place for more than a decade, its use in prelicensure education is relatively new. Other noteworthy innovations involving technology for classroom or clinical learning include the use of the social media networks, podcasting, and interactive audience participation systems such as clickers (Grimes, Joiner, Volker, & Ramberg, 2010; Schlairet, 2010; Sharoff, 2011).

Partnerships

Strategic partnerships are defined as relationships between two or more entities that involve the sharing of resources for mutual benefit (Dyer, Kale, & Singh, 2001; Gulati, 1995). Although several types of innovative partnerships were found in the literature, the majority were between an academic institution and a health care organization. The strategic intent of many partnerships focused on one or more of the following initiatives:

- Expand faculty, student, or clinical site capacity
- Advance educational progression–achieving the next level of education, for example, from an associate degree to a bachelor's degree.
- Build research capacity
- Facilitate transition to practice
- Create community partnerships
- Improve patient care for specific populations

Fetsch and DeBasio (2011) and Murray, Schappe, Kreienkamp, Loyd, and Buck (2010) describe a collaborative academic-service partnership that

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involves multiple academic institutions and health care organizations. The aim is to expand both faculty and student capacity by using staff nurses as clinical instructors, thus increasing student enrollment in the educational institutions. The expected outcomes are an increased pool of nursing educators, an expanded educational capacity within the community, and an innovative educational model that could be evaluated, disseminated, and replicated.

Burns and colleagues (2011) developed a regional consortium to expand student capacity by creating a centralized computerized clinical placement center and faculty resource center. According to Burns et al., the centralized clinical placement center facilitates student clinical placements, and the faculty resource center serves as a repository or per diem pool for potential faculty members. The per diem pool can be tapped by clinicians interested in teaching or by program administrators in need of nursing educators. Louie, Campbell, Donaghy, Rice, and Sabatini (2011) describe an innovative academic collaboration among four New Jersey state colleges and universities. These partners aim to increase the number of nurse educators by developing a graduate nursing program in which students pursue a career in nursing education and/or advanced practice.

Bowman et al. (2011) describe the Veterans Affairs Nursing Academy, which establishes partnerships between academic institutions and the U.S. Department of Veterans Affairs to expand faculty capacity, enhance the professional development of the clinicians serving as faculty, expand student capacity, and promote educational innovations (Bowman et al., 2011).

Other academic-service partnerships are designed to build research capacity within the academic institution and health care environment (Balakas & Sparks, 2010) to create partnerships with the community to meet the health care needs of vulnerable populations (Aponte & Egues, 2010) or to improve patient care and foster interprofessional education and collaboration (Berg, Wong, & Vincent, 2010; Debourgh, 2012; McCann, 2010; McKown, McKeon, & Webb, 2011).

Innovative Curricular, Classroom, and Clinical Strategies

Many of the innovative curricular and classroom strategies incorporate technology and distance education. Schreier, Peery, and McLean (2009) describe a paradigm shift from the traditional teacher-directed, content-laden curriculum to a student-centered, concept-based approach. This shift challenges both educators and students to leave the comfort zone of having the faculty provide content that the student absorbs. This new approach involves the use of active learning strategies that foster student engagement (Schreier, Peery, & McLean., 2009).

Table 1
Features of a Dedicated Education Unit

A dedicated education unit is an academic-service partnership with the following key features (Moscato, Miller, Logsdon, Weinberg, & Chorpenning, 2007):

- The hospital unit is an optimal teaching/learning environment through the collaborative partnership efforts of the academic and service institutions.
- The goal is to maximize the students' potential to achieve the learning outcomes or course objectives.
- Staff nurses are prepared for a clinical teaching role through collaborative staff development activities.
- The student remains with one staff nurse for the duration of the clinical rotation rather than being assigned to a different nurse based on the patient assignment.
- The staff nurse is coached on the teaching-learning process by the school-based nurse faculty, so the staff nurse can provide clinical instruction to the student in a one-on-one relationship.
- both the hospital and academic partner are committed to the process.

McCurry and Martins (2010) highlight the attributes of millennial learners as techno-savvy, digital natives who prefer interactivity, group exercises, and experiential learning. Woeber (2012) and Mill, Astle, Ogilvie, and Gastaldo (2010) found ways to use innovative classroom-based instructional strategies that foster active learning and student engagement. For example, students were given an assignment where they worked in pairs to organize pieces of subjective and objective data written on pieces of a puzzle into a coherent clinical note as part of an active learning group exercise.

The most commonly described innovation in clinical settings was the dedicated education unit, an innovative clinical teaching method designed to integrate the expertise of the staff nurse into the clinical learning of the student, facilitate the transition to practice, and improve clinical care (MacIntyre et al., 2009; Mulready-Shick, Katel, Bannister, & Mylott, 2009; Murray, Crain, Meyer, McDonough, & Schweiss, 2010). (See Table 1).

Caldwell, Tenofsky, and Nugent (2010) described an innovative clinical immersion experience in which the student is immersed in the clinical environment for three full shifts each week. This innovation allows for learning depth rather than breadth or variety in clinical experience (MacIntyre et al., 2009). The immersion experience better depicts the reality of nursing practice, provides an opportunity for the student to more fully interact and engage with the staff nurse, and allows the student to gain a deeper understanding of the operational aspects of the nursing unit (Caldwell, Tenofsky, & Nugent, 2010). The experience is believed to better enable the student to design, implement, and evaluate nursing care over a period of time (Caldwell et al., 2010).

Lewis (2010) describes the statewide initiative in Hawaii to establish a standardized nursing education curriculum similar to the Oregon Consortium for Nursing Education (OCNE) Model that would allow associate-degree nursing graduates to advance educationally by completing a baccalaureate degree in nursing in less time. The OCNE Model is a consortium of Oregon community colleges and the Oregon Health & Science University School of Nursing that shares a competency-based curriculum that allows associate-degree graduates from a community college campus to complete the baccalaureate degree requirements after 1 year of full-time study (Munkvold, Tanner, & Herinckx, 2012).

Discussion, Future Directions, and Next Steps

The innovations described in this article demonstrate that many nurse leaders and academicians have answered the call for reformation and innovation. Moreover, the leaders have clearly demonstrated the capacity for creativity and innovation in nursing education. These leaders have engaged in the process of dilemma flipping, that is, turning a complex problem into an opportunity, such as the development and implementation of a different and innovative model of clinical education. The architects of the innovative approaches described in this article flipped the limitations into opportunities and subsequently developed something new and responsive to a changing environment (Johansen, 2009).

Innovation can represent a microprocess of social change in the social system or, in this case, an initial reformation of nursing education by those nursing schools that have moved affirmatively with the innovation adoption decision (Rogers, 2003). Several factors affect innovation adoption decisions: the advantage of the innovation, the degree to which the innovation is compatible with existing beliefs and values, the complexity of adoption, the degree of flexibility in the innovative model, and the degree to which the innovation is visible to others (Rogers, 2003). Equally important is that early adopters work collaboratively with BONs to facilitate innovations that positively influence nursing education. Burke, Moscato, and Warner (2009) highlight a successful partnership between the BON and the school of nursing that enabled the school to advance its innovative initiatives. Some innovations may already be within the parameters of existing regulations. Many BONs have rules that allow for pilot projects or the provision of innovations (Burke, Moscato, & Warner, 2009).

It remains crucial to establish a process for formal evaluation of innovations. The evaluative process can provide feedback, lessons learned, and direction for others wishing to adopt or replicate an innovation. The challenge is that many innovative approaches lack common metrics or standardized ways to measure outcomes. The lack of commonalities is easy to understand when evaluating innovative clinical pedagogy. In a complex system such as a health care organization, components operate in a pattern, but interactions continually change. Many of the variables, such as the leadership, staff nurse commitment, preceptor availability, student cognitive ability, patient acuity level, and interactions with interprofessional team members, are organic. The variables are interacting continuously and unpredictably. Given this degree of complexity, how can one accurately evaluate or generalize findings given that the same starting point may produce different outcomes depending on the interactions of the variables? The Robert Wood Johnson Foundation's Evaluating Innovations in Nursing Education national program is making headway by supporting the evaluation of innovations that expand teaching or faculty capacity and student retention (Robert Wood Johnson Foundation [RWJF], 2011). This program is in its third cycle of funding innovations in nursing education projects, and descriptions of those funded projects are highlighted on the web-site, http://evaluatinginnovationsinnursing.org/. It is anticipated that the outcomes of these projects will inform faculty regarding strategies to prepare nurses for roles in a reformed health care system (RWJF, 2011).

The complexity associated with evaluating innovations underscores the rationale for developing an agenda for nursing education research. The steps toward development of a national agenda for nursing education research are to build the knowledge base nursing faculty can use to develop relevant, effective, quality educational models; to design rigorous nursing educational research, that is, improve the sophistication of the studies being conducted and the metric used for outcomes; to build disciplinary capacity for research; and to develop and test models for translating research into teaching practice (Valiga & Ironside, 2012).

Lastly, institutions must reflect on the costs and benefits of adopting innovative practices. What is the return on the investment? What is the value added? How does one cost share tacit knowledge and exchange resources that are difficult to cost out? Although there are no clear answers to these questions, they provide clear next steps and a future direction for developing financial models for innovation.

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Schedule Of Board Meeting Dates Through 2014

June 5-7, 2013
September 3-6, 2013
December 3-6, 2013
March 4-7, 2014
June 3-6, 2014
September 2-5, 2014
December 2-5, 2014

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

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Identifying and Minimizing Risk Exposures Affecting Nursing Practice to Enhance Patient Safety

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A study analyzing closed professional liability claims against nurses over a 5-year period was completed by CNA HealthPro and Nurses Service Organization. Of 516 closed claims, the average total incurred payment per claim was $204,594. The study identifies current liability patterns and trends and provides risk-control recommendations to enhance patient safety and minimize liability exposure. Study results indicate that nurses continue to be held strictly accountable for acting within their scope of practice as well as within the policies and procedures of their place of employment. The data also show a need for all spoken and written communication to be documented fully in the patient's health information record. The claims demonstrate that nurses are expected to serve as the patient's advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient's medical needs.

A good way for nurses to prevent exposure to legal liability is to understand–and avoid–the behaviors that have led to liability allegations in the past, and a recent comprehensive study of closed legal claims provides information and insight that can assist nurses as well as educators, administrators, and regulators. Conducted by CNA HealthPro and Nurses Service Organization (NSO), *Understanding Nurse Liability, 2006–2010: A Three-Part Approach* analyzes closed professional liability claims against nurses over a 5-year period and identifies current liability patterns and trends, including the most common types of allegations filed (CNA HealthPro and Nurses Service Organization, 2011b). The study also provides risk-control recommendations to enhance patient safety and minimize liability exposure. Thus, the study can help nurses identify their vulnerabilities and take appropriate actions to help ensure patient safety and minimize liability exposures.

Scope of the Study

The report analyzes claims involving registered nurses (RNs), licensed practical nurses (LPNs), and licensed vocational nurses (LVNs) that were closed between January 1, 2006, and December 31, 2010, and resulted in an indemnity payment of $10,000 or more. The complete report on the study has three parts: 1) statistical charts and analyses on 20 topics relating to nurses' professional liability claims, including risk-management recommendations and a self-assessment checklist (CNA HealthPro and Nurses Service Organization, 2011a); 2) data on eight topics relating to license-defense claims; and 3) 19 highlights from the NSO 2011 nurse work profile survey.

The database for the report was derived by applying specific exclusion criteria to the 3,222 closed claims attributed to CNA-insured nurses through the NSO program during this time period, narrowing the number of claims from 3,222 to 516.

The exclusion criteria were as follows:

- The claim closed before January 1, 2006, or after December 31, 2010.
- The closed claim was reported as an incident, never rose to the level of a legal action, and did not result in a payment by CNA.
- The claim closed with an indemnity payment of less than $10,000 on behalf of the insured nurse. (Closed claims with indemnity payments of less than $10,000 were excluded for many reasons, including the fact that they typically reflected less severe injuries and were resolved without extensive discovery actions, such as obtaining and assessing clinical records, expert opinions, and sworn depositions).
- The closed claim involved an advanced practice nurse (a nurse practitioner, clinical nurse specialist, certified nurse midwife, or certified registered nurse anesthetist).
- The closed claim involved a nursing assistant, nurse aide, or nursing student.
- The closed claim involved only legal representation for deposition assistance.

Professional Liability Claims

Of the 516 claims, 91.9% involved RNs, and 8.1% involved LPNs and LVNs. For purposes of the study, the term *incurred payment* represents the costs or financial obligations, including indemnity and expenses, resulting from the resolution of a claim. The average total incurred payment per claim was $204,594. The average for RNs was $211,489, and the average for LPNs and LVNs was $126,784. These data suggest that LPNs and LVNs tend to have fewer and less severe claims than RNs, possibly due to RNs' higher level of responsibility and the greater probability that RNs work in an acute-care setting.

The study found that an indemnity payment of $10,000 to $99,000 was made in 56.2% of the 516 claims, a payment of $100,000 to $249,999 was made in 24.8%, and a payment of $1,000,000 was made in 3.5%.

The specialties with the highest average indemnity payments were obstetrics, neurology/neurosurgery, and plastic/ reconstructive surgery. A possible emerging trend involved aesthetic services, which are most often provided by nurses under the direction of a licensed independent practitioner in the practitioner's office or clinic or in a spa. The scope of aesthetic services provided by nurses varies based on the state nurse practice act (NPA). The highest percentage of closed claims occurred in the medical/ surgical, gerontology, and obstetrics specialties. (See Table 1).

Claims involving scope of practice had the highest average indemnity payment, perhaps because practicing outside the scope is perceived as egregious misconduct. Claims with an allegation relating to scope of practice are thus difficult to defend successfully. Allegations related to patient assessment and monitoring were relatively common and resulted in high average paid indemnity. Allegations related to treatment/care accounted for the highest percentage of closed claims.

Allegations related to patients' rights, patient abuse, and professional conduct were reviewed as well. Patients have the right to receive care from a nurse who is properly trained, experienced, and competent to provide patient care. The costliest single claim in this category involved the death of a patient under the care of a nurse who was abusing illegal substances. The highest percentage of closed claims in this category involved violations of the patient's right to receive care in a safe environment. Allegations related to abuse included patient-to-patient abuse and physical, sexual, and verbal abuse of the patient by the nurse. (See Table 1).

LPNs and LVNs Compared With RNs

To help better understand risk exposure, the study compared the 43 closed claims in which the defendant was an LPN or LVN with the 473 RN closed claims. The study revealed these claim characteristics:

- LPNs and LVNs were defendants in 8.1% of the claims. The distribution of CNA/NSO-insured nurses, while fluid, is about 15% LPNs and LVNs compared with 85% RNs.
- The average indemnity payment for LPNs and LVNs of $83,213 was about half the average of $168,438 for RNs.
- The specialty with the highest average paid indemnity for LPNs and LVNs was surgery; for RNs, it was neurology/neurosurgery.

Table 1

Average Paid Indemnity by Nurse Specialty and Allegation (Closed Claims with Paid Indemnity ≥ $10,000)

	Percentage of Closed Claims	Total Paid Indemnity	Average Paid Indemnity
Nurse Specialty			
Obstetrics	10.3%	$20,264,713	$382,353
Neurology/neurosurgery	0.6%	$1,137,000	$379,000
Plastic/reconstructive surgery	0.8%	$1,297,500	$324,375
Pediatric/adolescent	2.7%	$3,486,250	$249,018
Behavioral health	1.7%	$1,367,500	$151,944
Correctional health	3.1%	$2,315,208	$144,701
Adult medical/surgical	40.1%	$29,801,615	$143,969
Emergency/urgent care	9.7%	$7,091,584	$141,832
Public/community health/hospice	8.9%	$6,368,790	$138,452
Gerontology – in aging services facility	18.0%	$9,327,317	$100,294
Aesthetic/cosmetic	3.7%	$821,875	$43,257
*Other	0.4%	$55,000	$27,500
Overall	100.0%	$83,334,352	$161,501
Allegation by Category			
Scope of practice	1.7%	$2,664,100	$296,011
Assessment	12.6%	$14,867,925	$228,737
Monitoring	6.8%	$7,814,875	$223,282
Treatment/care	58.5%	$47,370,806	$156,857
Medication administration	14.7%	$8,593,330	$113,070
Patients' rights/patient abuse/professional conduct	5.4%	$1,992,066	$71,145
Documentation	0.2%	$31,250	$31,250
Overall	100.0%	$83,334,352	$161,501

*"Other" specialties included a certified insulin pump trainer and a county-employed administrative nurse who reviewed state Department of Health nursing home recommendations.

Table 2
License Defense Paid Claims by Licensure and Allegation

RN		LPN/LVN	
Professional conduct	23.5%	Medication administration errors	25.4%
Improper treatment/ care	21.1%	Abuse/patients' rights	22.4%
Medication administration errors	19.7%	Improper treatment/care	19.4%
Abuse/patients' rights	13.7%	Professional conduct	15.2%
Documentation error or omission	8.2%	Assessment	5.5%
Scope of practice	6.1%	Monitoring	4.9%
Assessment	5.1%	Documentation error or omission	4.2%
Monitoring	2.6%	Scope of practice	3.0%
Total	100.0%	Total	100.0%

Note. The percentage indicated for RNs is based upon the 962 paid claims for RNs.The percentage for lPNs/lVNs is based upon the 165 paid claims for lPNs/lVNs.

Nurse License-Defense Paid Claims

An action taken against a nurse's license differs from a professional liability claim in that the disciplinary action may or may not involve allegations related to patient care and treatment. Also, the amounts paid in response to license-defense claims differ from those paid in response to liability claims. Disciplinary matters represent the cost of providing legal representation to the nurse, rather than indemnity or settlement payments to a plaintiff.

During the period for this report, there were 1,127 license-defense paid claims in which legal counsel defended nurses against allegations that could have led to license revocation. License-defense paid claims involved both medical and nonmedical regulatory board complaints against nurses. Claim characteristics analyzed include licensure type, location, allegation, and licensing board outcome.

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- Claims by Licensure Type: The percentage of license-defense paid claims by licensure type was 84.5% for RNs and 15.5% for LPNs and LVNs, which correlates with the proportion of RNs and LPNs/LVNs in the overall CNA/NSO-insured nurse population.
- Claims by Practice Location: RNs with a license-defense paid claim worked most often in a hospital setting (57.3%), followed by aging services facilities (19.6%) and home health services (7.9%). LPNs and LVNs with a license-defense paid claim were most likely to have worked in an aging services setting (56%), followed by hospitals (27.8%) and home health services (6.6%).
- Claims by Allegation Type: The four allegation classes with the highest percentages of license-defense paid claims were the same for RNs and LPNs/LVNs, although the order of prevalence differed. For RNs, the most common allegation was related to professional conduct (23.5%), followed by improper treatment/care (21.1%), medication administration errors (19.7%), and abuse/patient's rights (13.7%). For LPNs and LVNs, the most common allegation was related to medication administration errors (25.4%), followed by abuse/patient's rights (22.4%), improper treatment/care (19.4%), and professional conduct (15.2%; See Table 2).
- Any complaint filed against a nursing license can result in career-altering consequences, such as suspension, probation, license surrender, or license revocation. With regard to board complaint outcomes for paid license-defense claims, half of the board's final decisions resulted in no action, and 45.2% involved monitoring the nurse's practice, requiring further education, or issuing a caution. Only 4.8% of the decisions involved license surrender or revocation, terminating the nurses' careers.

A detailed view of the allegations related to professional conduct shows that drug diversion or substance abuse was the top allegation for RNs and LPNs/LVNs. Drug diversion or substance abuse allegations included diversion of medication for self or others, failure to document proper disposal of narcotics, inaccurate medication counts not reported/detected, and apparent intoxication from alcohol or drugs while on duty. Nursing professionals must recognize the stress factors that may lead to unprofessional conduct and be proactive in seeking support to manage challenging situations or circumstances.

Allegations related to patients' rights and patient abuse represented 13.7% of the total allegations for RNs and 22.4% for LPNs and LVNs. Physical abuse allegations ranked highest for both RNs at 4.7% and LPNs/LVNs at 12.1%. The ability to manage difficult patient situations is a core nursing competency. Developing communication and relationship skills for a diverse patient population qualifies as an essential risk-control tool for nurses, minimizing exposure to allegations of abuse and violation of patients' rights.

Table 3

Continued Education Credits Required and Average Paid Indemnity

Credits	Nonclaims	Claims	Average Paid Indemnity
None	28.0%	21.4%	$24,851
Less than 30	41.9%	40.2%	$17,491
30 to 60	30.1%	38.2%	$15,623

Qualitative Nurse Work Profile Survey

Part III of the report presents selected highlights from the NSO's 2011 Qualitative Nurse Work Profile Survey, which was conducted to compile data from nurses about issues that are not addressed by the analysis of closed claims (Nurses Service Organization, 2011). The purpose of the survey was to examine the relationship between professional liability exposure and a variety of demographic and workplace factors. The survey participants included RNs, LPNs, and LVNs who participated in the NSO insurance program between January 1, 2006, and December 31, 2010. The responding nurses were divided into two groups: those who had experienced a professional liability claim resulting in a loss and those who had never experienced a claim. The claims group consisted of 1,617 nurses. The non-claims group included a randomized sample of currently insured nurses approximately matching the demographic characteristics of those who experienced closed claims.

Here is a summary of the findings:

- The majority of respondents with claims (69.2%) had been in nursing practice for 16 years or more at the time of the incident that resulted in a claim. The longer respondents worked as nurses, the greater the number of claims. The highest percentage of closed claims involved nurses who had worked more than 21 years. Also, a correlation existed between the average paid indemnity and the number of years in the profession.
- The highest proportion of respondents with claims had bachelor's degrees, followed by those with associate's degrees, those from diploma programs, those with master's degrees, and those with doctorate degrees. Indemnity payments were higher for claims from respondents who had completed a nursing diploma program than from respondents with a bachelor's or associate's degree.
- Respondents who did not have a mentor or preceptor during their first 2 years as a nurse experienced higher average paid indemnities than those who did. Most respondents with a mentor or preceptor indicated that the mentor or preceptor was a nurse colleague or staff nurse. Respondents who had a nurse manager or director as a mentor had the highest average indemnity payments. Respondents mentored by a nurse practitioner, clinical nurse specialist, or physician had the lowest average indemnity payments.
- Continuing education was associated with decreased average indemnity payments. As the number of required credits for such programs increased, the average paid indemnity decreased. (See Table 3).
- The existence of an organization/facility policy for disclosing mistakes resulted in a 50% decrease in the average paid indemnity. One-fourth of the respondents stated their facility did not have a policy for disclosing mistakes, and a third stated they did not know if such a policy existed.
- Although the use of electronic medical records is increasing, 64.6% of respondents who experienced claims used handwritten records at the time of the incident. Average paid indemnity decreased when electronic medical records were used exclusively.
- Interaction with management was associated with decreased average paid indemnity. Respondents who noted they felt comfortable turning to management for help had a lower average paid indemnity than those who did not. Those who said they were afraid to contact management concerning the incident had the highest average paid indemnity.

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Risk-Control Recommendations

The closed claims data suggest that many errors are predictable and preventable. Therefore, ongoing attention to regulatory requirements and development and enhancement of core competencies can increase patient safety while minimizing nurses' liability exposure. Compliance with critical processes, such as performing careful documentation and understanding and invoking the chain of command, is essential in every nursing setting, clinical specialty, and position. The basic strategies below can serve as a starting point for nurses seeking to assess and enhance their safety practices.

Follow the state's scope of practice and NPA and the facility's policies, procedures, and protocols. Nurse employers are required to establish position descriptions and policies in compliance with state regulations. If regulatory requirements and organizational scope of practice or policies differ, comply with the most stringent of the applicable regulations or policies. The following additional strategies can help reduce the likeli-hood of scope-of-practice allegations:

- If a job description, contract, or set of policies and procedures appears to violate the legal scope of practice, bring the discrepancy to the organization's attention.
- State clearly that you are unwilling to risk license revocation and legal action by failing to comply with the scope of practice or NPA.
- Know the organization's policies and procedures related to clinical practices, documentation, and steps required if given an assignment beyond the legal scope of practice or personal nursing experience.

Develop, maintain, and practice professional written and spoken communication skills. Effective communication–which involves the exchange of accurate, timely, complete, appropriate information–is essential to working with patients, families, administrators, practitioners, and other members of the patient care team in an efficient and appropriate manner. The following communication strategies can enhance information flow and help create a more patient-centered and caring atmosphere:

- Always consider which information to share, when to share it, how to share it (for example, in writing, in person, or via telephone), and with whom to share it.
- Ensure that communication among caregivers and between caregivers and patients is professional, respectful, and inclusive. As the caregiver with the most access to the patient, the nurse is often the one who ascertains the patient's needs and wishes and conveys them to others. Include family members or significant others in discussions only if the patient or designated legal representative has given authorization.
- Determine the patient's primary language, follow organizational procedures to obtain translation/interpreter services, and ensure that the patient receives information regarding condition and treatment in his or her primary language.
- Carefully communicate patient assessments and observations to other health care team members to develop and modify the plan of care as necessary.
- Utilize sound handoff methods. Failure to adequately communicate during patient handoffs is a common contributing factor to delays and errors. Be sure to convey key information related to acute and chronic conditions, including allergies and special needs. Ensure that critical information has been shared whenever the patient is transferred to another caregiver or environment.

Maintain clinical competencies relevant to the patient population and health care specialty. Nurses have a duty to proactively obtain the professional information, education, and training needed to remain current regarding clinical practice, medications, biologics, and equipment used in the treatment of acute and chronic illnesses and conditions related to their specialty. Continuing nursing education programs represent an important mechanism for meeting this responsibility. If such programs are not routinely provided by the employer, contact state and local nurse associations for information about reputable education and training offerings.

Invoke the chain of command when necessary to focus attention on the patient's status or any change in condition. Nurses are the patient's advocate, ensuring that the patient receives appropriate care when needed. Advocacy includes the duty of invoking the nursing and medical staff chains of command to ensure timely attention to the needs of every patient and persisting to the point of satisfactory resolution. Nurses must be comfortable with utilizing the medical chain of command when a practitioner does not respond to calls for assistance, fails to appreciate the seriousness of a situation, or neglects to initiate appropriate intervention. The following strategies can help reduce apprehension regarding chain of command issues:

- Address communication issues between nursing and medical staffs and identify instances of intimidation, bullying, retaliation, or other deterrents to invoking the chain of command.
- Notify leadership of individuals or areas that prevent nursing staff members from invoking the chain of command or that punish them for doing so.
- If the organization's current culture does not support invoking the chain of command, explain the risks posed to patients, staff, practitioners, and the organization and initiate discussions regarding the need for a cultural shift with administration, risk management, and/or legal counsel.

Conclusion

This analysis of professional liability claims reveals that nurses continue to be held strictly accountable for acting within their scope of practice as well as within the policies and procedures of their place of employment. Many claims develop from a failure involving core competencies, such as patient assessment, monitoring, treatment and care, practitioner and patient communication, timely and complete documentation, and invocation of the chain of command.

The claims demonstrate that nurses are expected to serve as the patient's advocate and are responsible for obtaining alternative practitioner intervention if the initial practitioner does not respond appropriately to the patient's medical needs. Another lesson reinforced by the data is the need for all communication, spoken and written, to be documented in the patient's health information record.

We anticipate that the data, analysis, risk-control recommendations, and self-assessment checklist contained in the full report will inspire nurses nationwide to examine their practices carefully and focus their risk-control efforts on the areas of statistically demonstrated error and loss.

The information, examples, and suggestions contained herein have been developed from sources believed to be reliable, but they should not be construed as legal or other professional advice. For the full report and complete 2011 nurse survey, visit www.cna.com and www.nso.com/nurseclaimreport2011.

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Professionalism Extends Beyond the Workplace

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While driving home from a party, a nurse was involved in a one-car accident. The nurse pled no contest to a misdemeanor count of driving under the influence of alcohol (DUI). Though the nurse was off duty and had no prior disciplinary actions, no prior DUI convictions, and no apparent alcohol abuse or dependency issues, the board of nursing (BON) determined that the DUI conviction was evidence of unprofessional conduct and placed the nurse's license on probation for 3 years. Subsequently, the BON's action was upheld by the appellate court. This article reviews the case and the legal and ethical foundations of the BON's decision.

A nurse who decided to drive home after having some drinks collided with the center divider of a highway. Luckily, no one was injured in the one-car accident. Authorities measured the driver's blood alcohol level at 0.16%, twice the legal limit. The nurse pled no contest to a count of driving under the influence of alcohol (DUI; Egelko, 2012).

The DUI incident did not occur while the nurse was on duty, and it appeared to be an isolated event. A substance use evaluation determined the incident was not indicative of a substance use disorder. The nurse was not a bad nurse or a bad person. However, the nurse did make a bad decision to drink and drive, and that decision resulted in unprofessional behavior. The California Board of Nursing (BON) and the California Appellate Court determined that the nurse's behavior outside of working hours was evidence of unprofessional conduct and placed the nurse's nursing license on probation for 3 years (Sulla v. Board of Registered Nursing, 2012).

DUI Conviction: Evidence of Unprofessional Conduct

To understand why the BON – and subsequently, the court – regarded the nurse's DUI conviction as conclusive evidence of unprofessional conduct, consider the principles of nursing professionalism, the nursing code of ethics, and the California Nursing Practice Act.

Commonly, nursing is referred to as a profession, not a job. Unlike a job, a profession is a chosen, paid occupation requiring prolonged training and formal qualification (Gokenbach, 2012). As such, nurses are professionals and can be defined as individuals expected to display competent and skillful behaviors in alignment with their profession. Therefore, the values of the profession must drive the professional's beliefs and behavior (Gokenbach, 2012). Obligations of professionalism and practice implicitly and explicitly embedded in codes and regulations require nurses to conduct themselves with respect, confidentiality, moral courage, and cultural sensitivity and to act as good citizens of the world (Butts, 2013).

Codes of ethics provide explicit guidelines for the profession. The American Nurses Association's *Code of Ethics* clearly delineates duties to self and others as well as the responsibilities to preserve integrity and safety, to maintain competence, and to continue personal and professional growth (American Nurses Association [ANA], 2011). Further, the code states that moral self-respect accords moral worth and dignity to all, including oneself. Identifying common ethical concerns, such as professional growth and maintenance of competence in the field of nursing, the code also notes the "preservation of wholeness of character, and personal integrity" as ethical guidance to all members of the profession (ANA, 2011; see Table 1).

Table 1

Expectations of the Code of Ethics

Provision 5 of the American Nurses association's *Code of Ethics for Nurses With Interpretive Statements* reads as follows:

Provision 5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

5.1. Moral self-respect. Moral respect accords moral worth and dignity to all human beings irrespective of their personal attributes or life situation. Such respect extends to oneself as well; the same duties that we owe to others we owe to ourselves. Self-regarding duties refer to a realm of duties that primarily concern oneself and include professional growth and maintenance of competence, preservation of wholeness of character, and personal integrity (American Nurses association, 2011).

All can agree that driving while under the influence of alcohol endangers not only the driver, but other drivers and pedestrians. This behavior demonstrates a lack of respect for the integrity and safety of oneself and others. Therefore, driving while intoxicated is a behavior that fails to align with the nursing profession's moral obligation of professionalism or of a good citizen of the world.

The California Nursing Practice Act explicitly requires a nurse to exhibit behaviors consistent with professionalism within and outside the workplace. The act specifically directs nurses on the professional expectations concerning the use of alcohol and convictions related to alcohol misuse. See Table 2 for specific legislative language regarding alcohol use and convictions (California Nursing Practice Act, 2011).

Table 2

California Nursing Practice Act: Alcohol Use and Convictions

On the subject of drug-related – including alcohol-related – transgressions, the California Nursing Practice act states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof (California Nursing Practice act, 2011).

The actions of a nurse will be judged by the standards of the profession as well as by the law that guides and governs the nurse. BONs are required to protect the public by reviewing the conduct of the nurse, applying the law to the nurse's actions, and determining a disciplinary sanction for any violations (Russell, 2012). The following summary of the findings of the administrative hearing, district court, and appellate court serves to further illuminate the disciplinary process regarding this incident of unprofessional conduct.

Administrative Hearing

As a result of the DUI conviction, the California BON filed an accusation alleging that the conduct of the nurse warranted discipline under several provisions of the nursing practice act. The matter proceeded to a hearing in front of an administrative law judge (ALJ). During the hearing, attorneys for the nurse argued that a criminal conviction could not provide grounds for discipline unless the misconduct substantially related to the qualifications, functions, and duties of the profession (Sulla v. Board of Registered Nursing, 2010, p. 4).

The ALJ reviewed the behavior underlying the nurse's conviction and found that it did not reflect, to a substantial degree, a present or potential unfitness to practice nursing (Sulla v. Board of Registered Nursing, 2010, p. 5). *However, the ALJ determined that the nurse violated two provisions of the nursing practice act that do not require a substantial relationship between the nurse's misconduct and professional fitness, § 2762 (b) and (c). The first provision provides that a nurse violates professional conduct by using "alcoholic beverages, to an extent or in a manner dangerous to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license"*

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(Sulla v. Board of Registered Nursing, *2010, p. 5; see Table 2). The second provision defines unprofessional conduct as including "a criminal offense involving the . . . consumption . . . or self-administration of alcohol"* (Sulla v. Board of Registered Nursing, *2010, p. 4; see Table 2*).

Under the authority of these two provisions, the ALJ ordered the revocation of the nurse's license as a result of the DUI conviction (although the judge stayed the revocation subject to 3 years' probation).

The ALJ read the existing law as requiring professional conduct at all times by one licensed as a nurse. Further, the ALJ noted there was no requirement in the nursing practice act that a "substantial relationship" exist between the DUI conviction and professional fitness because the particular violation was explicitly recited in the nursing practice act (Sulla v. Board of Registered Nursing*, 2010, p. 5*).

Two Appeals

The nurse appealed the ALJ's finding and the BON's disciplinary action to the San Francisco Superior Court, which overturned the BON's decision, finding that the imposition of discipline required a substantial relationship between the conviction and the qualifications, functions, or duties of a registered nurse (Sulla v. Board of Registered Nursing, *2011*).

The BON then appealed the decision, and in response, the nurse made two general arguments. First, the nurse asserted that due process requires a finding of a nexus, or logical relationship, between misconduct and professional qualification before the BON may impose professional discipline. Secondly, the nurse argued that the BON violated equal protection by imposing discipline after a single alcohol-related conviction, while the Medical Board requires two alcohol-related convictions prior to disciplining a physician. The Court of Appeals overturned the Superior Court and reinstated the original ruling of the ALJ imposing discipline on the nurse's license (Sulla v. Board of Registered Nursing, *2012*).

Rationale of the Appellate Court

The appellate court maintained that the nursing practice act did not explicitly require the BON to establish a nexus between the conduct described and the licensee's professional fitness (*Sulla v. Board of Registered Nursing,* 2012, p. 1201). In addition to the explicit language of the pertinent statute (Table 2), the court extrapolated case law from three analogous instances of physician discipline by medical boards because the court had not previously considered similar actions by the BON.

First, the court cited a case clearly noting that a medical board may discipline physicians for personal drug use without showing that the drug use impacted the physician's professional ability (*Sulla v. Board of Registered Nursing,* 2012, p. 1202, citing *Weissbuch v. Board of Medical Examiners,* 1974). The court found that the constitution provided no basis for imposing a special requirement of nexus, especially since the legislative language explicitly defines unprofessional conduct as including a conviction related to alcohol misuse.

In the second case relied upon by the court, the facts revealed that three misdemeanor drunken driving offenses constituted conclusive evidence of professional misconduct and grounds for discipline. There, a logical nexus between misconduct and professional qualification existed because driving under the influence reflects a lack of personal and professional judgment, threatens public safety, and demonstrates a lack of medical knowledge of the effects of alcohol and legal prohibitions against drinking and driving (*Sulla v. Board of Registered Nursing*, 2012, p. 1203, citing *Griffiths v. Superior Court*, 2002). In other words, an implicit nexus exists between alcohol-related misconduct and professional fitness, even if the transgression does not occur during the actual practice of medicine.

Finally, the court referred to a case upholding the discipline of a physician with several DUI arrests, but no convictions. In this case, the court required a nexus between the type of misconduct underlying the discipline and the ability of the physician to practice medicine (*Sulla v. Board of Registered Nursing*, 2012, pp. 1203–1204, citing Watson v. Superior Court, 2009). However, a logical connection exists if the conduct of the licensee endangers himself, another person, or the public generally (*Sulla v. Board of Registered Nursing*, 2012). Three DUI arrests, even without a conviction, represented sufficiently dangerous misconduct logically connected to an inability to professionally practice medicine (Sulla v. Board of Registered Nursing, 2012).

Drawing from these cases, the Court of Appeals maintained that a nexus or logical relationship existed between the professional fitness of a registered nurse and the alcohol-related misconduct because the nursing practice act specified the nexus by including in the relevant portion of the definitions of unprofessional conduct a conviction related to alcohol misuse. Therefore, the statute did not violate due process by conclusively presuming professional unfitness and authorizing the BON to impose discipline. In other words, whether a conviction is "substantially related" to professional qualifications is a question of law, not fact. It does not matter whether the ALJ found, as in this case, that the nurse's conduct did not substantially relate to his professional qualifications. The BON may exercise authority to discipline according to statute without independently proving a "substantial relationship" (*Sulla v. Board of Registered Nursing*, 2012, p. 1206).

Also, the Court of Appeals quickly disposed of the nurse's claim that the statute governing the regulation of nurses violated equal protection. The nurse argued that imposing discipline on nurses for a single alcohol-related incident violated the constitution because a similar statute governing the regulation of physicians required more than one such conviction to form the basis of disciplinary action (*Sulla v. Board of Registered Nursing,* 2012, p. 1207). The court explained that legislatures may treat members of various professions dissimilarly, unless such treatment is "palpably arbitrary and beyond rational doubt erroneous" (*Sulla v. Board of Registered Nursing,* 2012).

Implications

Guidance on the definition of acts that will be considered unprofessional is found in each state's nurse or nursing practice act or rules and regulations. As seen in this case, the California Nursing Practice Act does not require that unprofessional conduct be substantially related to the practice of nursing. California is very specific in its definition of unprofessional conduct related to a conviction for alcohol misuse (California Nursing Practice Act, 2011, §2762 (c)). Among other states, both Missouri and New Hampshire also specifically include alcohol misuse as grounds for discipline within their nurse practice acts. (See Table 3).

Table 3

Grounds for Discipline Related to Alcohol Use in the Missouri and New Hampshire Nurse Practice Acts

Missouri	New Hampshire
Violation of the drug laws or rules and regulations of this state, any other state or the federal government (Missouri Nurse Practice act, 2012).	(p) Other drug-related actions or conduct that include but are not limited to: (1) Use of any controlled substance or any drug or device or alcoholic beverages to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public, or to the extent that such use may impair his or her ability to conduct with safety to the public the practice of nursing (New Hampshire Nurse Practice act, 2012).

Arkansas provides specific acts in its legislative definition of unprofessional conduct:

- Failing to assess and evaluate a patient's status
- Unlawfully appropriating medications
- Providing inaccurate or misleading information regarding employment history to an employer
- Failing a drug screen
- Failure to repay loans to the nursing student loan fund (Arkansas Administrative Procedures Act, 2008).

In addition, Arkansas law gives the BON great discretion by further defining unprofessional conduct as any other conduct that, in the opinion of the board, is likely to deceive, defraud, injure, or harm a patient or the public by an act, practice, or omission that fails to conform to the accepted standards of the nursing profession (Arkansas Administrative Procedures Act, 2008).

Vermont also provides the BON with discretion via its nurse practice act by defining unprofessional conduct as including "conduct of a character likely to deceive, defraud, or harm the public" (Code of Vermont Rules, 2012).

Conclusion

Nurses must never lose sight of the fact that they are licensed professionals, and the nursing license brings broad responsibilities (Trentham, 2011). There is a duty to be informed about the laws that guide and govern the nursing profession (Russell, 2012). Nurses also have the duty to recognize that as a part of the license to practice in the nursing profession, one is considered a professional at all times. As the court in this case noted, "driving under the influence reflects a lack of sound professional and personal judgment, threatens the safety of the public, and demonstrates both a disregard of the medical knowledge of the effects of alcohol and the legal prohibitions against drinking and driving" (*Sulla v. Board of Registered Nursing*, 2012, p. 1203 citing *Griffiths v. Superior Court,* 2002).

Quite simply, nurses do not leave their nursing license and professionalism at the workplace door.

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Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

CENSURE

Brown, Mary S.
Elsberry, MO
Registered Nurse 131188
Licensee practiced as a nurse on a lapsed license from April 30, 2009, through August 21, 2012.
Censure 01/23/2013 to 01/24/2013

Harris, Maria Catherine
Monroe City, MO
Registered Nurse 2008017964
The Board did not receive proof of support group attendance by the August 16, 2012 documentation due date. The Board did not receive a thorough chemical dependency ongoing treatment evaluation submitted on Respondent's behalf, by the documentation due date of November 16, 2012.
Censure 12/20/2012 to 12/21/2012

DeMeire, Judah Abram
Kansas City, MO
Licensed Practical Nurse 2006022579
A resident fell on December 2, 2011 at 0800. Licensee knew the resident had a history of combative behavior. After resident was helped off the floor, licensee viewed the resident's condition and asked her if she was hurt. Licensee did not contact the resident's physician. He contacted H.T., the medical assistant for the physician, about the fall. H.T. later informed the physician, Dr. F., of the fall. The physician was in the building at the time. When Dr. F. assessed the patient at approximately 1100, her injuries were significant. Dr. F. noted in his assessment that the resident had a broken rib, which was confirmed by x-ray. The resident did not have further assessments at that time after the one conducted by Dr. F. When licensee was asked for the resident's vital signs and neurological checks, he had not documented them and was unable to locate them. Licensee then picked up a piece of paper that contained the names of patients who did not have alarms on their beds, put it in his pocket and went to the restroom. When he returned from the restroom he produced the piece of paper that now had a set of vital signs on it for the resident. Licensee later asked the supervisory staff if he could re-document the resident's care, and was refused by the staff.
Censure 01/18/2013 to 01/19/2013

Eades, Robert Allen
Saint Charles, MO
Registered Nurse 2000171873
Respondent's license is subject to discipline for being disciplined by the Arizona state board of nursing for conduct that would have been disciplined had it occurred in Missouri and for failing to answer questions truthfully in regard to his criminal history when he applied to the Missouri Board of Nursing.
Censure 01/11/2013 to 01/12/2013

Phillips, Janet Leigh
Stover, MO
Licensed Practical Nurse 2010004929
On November 9, 2011, Licensee pled guilty to the class A misdemeanor of stealing.
Censure 02/15/2013 to 02/16/2013

Chartrand, Rose M.
East Carondelet, IL
Registered Nurse 2001029042
Cause exists to discipline the nursing license of Rose Chartrand for providing a third party with a medical release form from her employer and excusing the third party from school when he was not a patient of her employer.
Censure 01/24/2013 to 01/25/2013

Callow, Monti Jean
Cape Girardeau, MO
Registered Nurse 2001030515
Cause exists to discipline the nursing license of Monti Callow for video taping a patient during treatment without the patient's permission.
Censure 01/24/2013 to 01/25/2013

CENSURE Continued....

Smith, Anthony W.
La Monte, MO
Registered Nurse 2001003241
The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of October 20, 2012. The Board did not receive proof of any completed hours for any of the continuing education classes required by the October 15, 2012 due date.
Censure 01/09/2013 to 01/10/2013

Jackson, Patricia Ann
Sikeston, MO
Licensed Practical Nurse 2007024454
Licensee was an in-home nurse. Licensee worked for the patient on December 5, 2011. On December 5, 2011, Licensee plugged her personal phone into the patient's home computer to charge the phone's battery. Licensee's phone automatically downloaded Licensee's pictures to the patient's home computer. On December 6, 2011, the patient's mother discovered the photographs on her computer. The patient's mother saw a photograph of her daughter (the patient) that Licensee had taken. The computer also had a video that Licensee had recorded of Licensee cleaning the feeding tube button of the patient. Neither the patient nor her mother signed any release or consent to allow Licensee to take the pictures or video.
Censure 01/01/2013 to 01/02/2013

Martinez, Maggie Mae
Sedalia, MO
Licensed Practical Nurse 2005011435
Respondent failed to timely complete required continuing education classes.
Censure 12/27/2012 to 12/28/2012

Ison-Moyer, Edna L.
Union Star, MO
Registered Nurse 141564
Licensee worked from May 1, 2011 through September 20, 2012, on a lapsed license.
Censure 12/27/2012 to 12/28/2012

Christopher, Christine A.
Saint Louis, MO
Licensed Practical Nurse 036738
Licensee practiced nursing in Missouri without a license from October 14, 2010 through February 7, 2012.
Censure 02/13/2013 to 02/14/2013

Rosenkoetter, Marcia G.
Springfield, MO
Registered Nurse 056569
Licensee worked on a lapsed license from May 1, 2011 through May 29, 2012.
Censure 12/25/2012 to 12/26/2012

Bagato, Judy A.
Greenville, IL
Registered Nurse 082092
Licensee worked in a treatment center. During the time she worked at the Center, Licensee regularly signed orders for prescription narcotics in the handwriting style of the physician. The narcotics included Oxycodone, Fentanyl, Endocet and Percocet. When the physician prescribed medication, Licensee would not write the physician's name and then sign her name, but would imitate the handwriting of the physician and sign his name. Licensee did this for two different physicians at the Center. Licensee also signed the physicians' names on the 340 B forms, a form mandated by the United States Department of Health and Human Services for changes in participation or medication related to the center's participation in the 340B Drug Pricing Program. The physicians had knowledge of this practice.
Censure 12/25/2012 to 12/26/2012

Person, Juanita A.
Saint Louis, MO
Registered Nurse 2012026954
Respondent failed to call in to NTS on eight (8) different days. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the documentation due date.
Censure 01/09/2013 to 01/10/2013

Herman, Sarah Elizabeth
Excelsior Springs, MO
Licensed Practical Nurse 2012010824
Respondent failed to timely submit employer evaluations, proof of completion of required continuing education courses, and a signed summary of her meeting with the discipline administrator.
Censure 12/27/2012 to 12/28/2012

Bot-Baron, Marcy A.
Springfield, MO
Registered Nurse 135489
Cause exists to discipline the nursing license of Marcy Bot-Barron for disclosing information concerning a patient's test results without authority to release the information.
Censure 01/24/2013 to 01/25/2013

Censure continued on page 16

The Board of Nursing is requesting contact from the following individuals:

Jamie Adams–PN 2011006799
Nahdeen Joseph–PN20050345418
Christine Larkin–PN 045845
Helen McMellen–PN 035718
Nancy Noble–RN 124505
Bob G. Ruth–RN 142411
James Shafer–RN 143088
Veronica Sutherland–PN 2002027451
Tammy Wilcox-Smith–RN 111848

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

Censure continued from page 15

King, John Frederick
Olivette, MO
Registered Nurse 2009004411
Licensee was caring for a patient in the Cardiology Intensive Care Unit (CICU) at the hospital. Licensee was preparing to administer Heparin via a syringe to the patient. The patient refused to listen to any explanation and declined the medication. Licensee then waited a few moments and administered the Heparin shot without the patient's consent. Licensee did not check with the patient's treating physician or any other physician before administering the shot to determine whether she should be medically documented or charted as being unable to make decisions on her own.
Censure 02/13/2013 to 02/14/2013

Moser, Jerry Dee
Dexter, MO
Registered Nurse 2004024139
On June 29, 2011, Licensee was disciplined orally for patient abuse for his actions while transferring a patient. While transferring a patient, Licensee told her "not to make him mad" and admitted to growling at the patient. On June 28, 2011, a patient was moaning in distress in a room on a floor on which Licensee was working. When a medical assistant asked Licensee why, Licensee responded crudely. Another RN assessed the patient,and found her in distress. On June 10, 2011, Licensee was counseled in writing to stop doing puzzles while on duty. On June 7, 2011, Licensee did not prepare his patient for a colonoscopy. He had been responsible for ensuring a patient was clean on his night shift for the patient's scheduled colonoscopy the next morning, but when asked, did not know if the patient was clean or not. On May 17, 2011, Licensee was counseled in writing on leaving a monitored telemetry patient unattended in the x-ray department. On May 4, 2011, Licensee had removed Ambien and Xanax at 2029 and then again at 2039. Licensee did not document the administration/waste of a dose of Ambien or Xanax, thus leaving both medications unaccounted for. On May 12, 2011, Licensee was counseled in writing of his poor ability in starting I.V.s and that he was starting the I.V. in a painful manner and that a patient thought the I.V. had gone through a tendon. On May 6, 2011, Licensee wrote a telephone order on the wrong patient's chart. On April 7, 2011, Licensee was working at the nurse's desk at the Telemetry Unit. Licensee gave details of a patient's status, tests, results, medicines and care to an unidentified visitor who did not give the proper password verification. On March 30, 2011, Licensee was counseled in writing on his informing a patient that she had AIDS and was positive for HIV. Licensee did not have a diagnosis or documentation to support such a diagnosis, nor did he verify it. On February 3, 2011, Licensee was counseled orally in a meeting with hospital staff for using profanity on the job and it was noted that he had just previously been counseled on using profanity on the job only a few days before. On February 3, 2011, Licensee was counseled orally in a meeting with hospital staff for blood administration errors he had made. Licensee administered blood but failed to check for pre-transfusion meds, that the patient's teaching was done, or that the patient understood the procedure. On February 1, 2011, Licensee received a call from a patient who also worked there. The patient stated he needed assistance to go into his bathroom, but Licensee never responded and the patient suffered from diarrhea which went all over the floor, causing the patient great embarrassment. On January 27, 2011, Licensee was counseled in writing on an incident that occurred on January 26, 2011, when an alarm bed sounded for a male patient. Licensee crudely spoke to the patient about what a catheter is. On the same date Licensee was also counseled in writing for using profanity and denigrating the presence of family members on the floor.
Censure 12/18/2012 to 12/19/2012

CENSURE Continued....

Clark, Karen Sue
Columbia, MO
Registered Nurse 2007000466
Respondent failed to submit to a drug and alcohol screen on a date when required to do so with a Board-approved third-party administrator, and for testing positive for alcohol on another date.
Censure 12/27/2012 to 12/28/2012

Short, Jill Ann
Deepwater, MO
Licensed Practical Nurse 2003022401
On February 15, 2012, at 1020, Licensee took vital signs on a patient. The patient had a blood pressure of 72/50 and a heart rate of 120-160. Licensee notified Dr B of the vital signs over the phone and Dr B told licensee at 1025 he was giving licensee orders for a troponin blood level check and an order for digoxin and it was needed STAT, or very quickly. When Dr B arrived on the unit at 1125, (approximately one hour later) the orders were not completed. Licensee had "written" the orders down at 1025 but did not put it into the computer, which is a prerequisite to any action taking place on the order. Licensee then put the telephone order into the computer at 1139 when she became aware that it was not in the computer, but "timed" the order as 1025 in the computer. Licensee's actions resulted in a significant delay in PS receiving proper treatment. On December 13, 2011, on another patient, Licensee was counseled about not charting a respiratory assessment and not charting rounds since the beginning of the shift at 1100. The patient was dismissed at 1700 with no further assessments. Licensee also did not document a discharge note on the patient. On January 28, 2012, Licensee was counseled about not getting a patient ready for discharge, and the need for documentation generally and why it was important and critical to patients' health. On February 14, 2012, Licensee was counseled regarding her inappropriate behavior at a "skills fair" at Golden. Licensee had difficulty in the assessment station, was unable to identify lung sounds, and was unsure of the critical steps to take with a congestive heart failure patient. Licensee was also not clear of the information being asked of her in a surgical patient scenario.
Censure 02/21/2013 to 02/22/2013

Garrett, Sharon Renee
Doniphan, MO
Registered Nurse 2007022404
Licensee was subject to discipline for failure to follow a physician's orders on two different occasions.
Censure 01/05/2013 to 01/06/2013

Love, Venita Nadine
Saint Joseph, MO
Licensed Practical Nurse 2005007078
On December 10, 2007, Licensee attempted to assist staff in placing a violent patient in seclusion. The patient was striking, spitting, and kicking. However, staff was able to calm the patient down to a manageable degree. At this time, Licensee moved close to the patient's face and started to speak aggressively to the patient. Licensee's comments were aggressive, emotional, and counterproductive. The patient's aggressiveness increased with these comments.
Censure 12/20/2012 to 12/21/2012

PROBATION

Claerhout, Tammy K.
Independence, MO
Licensed Practical Nurse 056770
On September 6, 2005, Licensee pled guilty to the class D felony of fraudulent use of a credit/debit device On September 6, 2005, Licensee pled guilty to the class C felony of forgery on October 3, 2008, Licensee pled guilty to the class D felony of attempted theft/stealing (value of property or services is $500.00 or more but less than $25,000.00) In her renewal application, Licensee admitted to smoking methamphetamine and marijuana in the past.
Probation 12/18/2012 to 12/18/2017

Cooper, Yvonna Faye
Fredericktown, MO
Licensed Practical Nurse 2000172305
On June 2, 2011, Respondent's drug screen was positive for THC, a metabolite of marijuana.
Probation 01/09/2013 to 01/09/2018

McWilliams, Melinda L.
Olathe, KS
Registered Nurse 2007018834
On February 18, 2011, a patient complained that Licensee had taken one of her Ativan. A Pyxis review revealed that Licensee had removed three Ativan doses for the patient. Licensee only documented the administration of two Ativan doses to the patient and failed to document the administration or wasting of the third dose. On February 20, 2011, the Charge Nurse found two Percocet on the table in the staff room near Licensee's lunch bag. A Pyxis review revealed that Licensee had removed two Percocet for a patient. Licensee documented that she had administered the Percocet when she had not. A Pyxis report identified over sixty narcotic discrepancies that involved Licensee. Licensee admitted to diversion.
Probation 01/23/2013 to 01/23/2018

Ward, Clyde Edward, II
Hannibal, MO
Registered Nurse 2010035656
On December 9, 2011, Licensee entered into a Consent Order with Stipulations with the State of Illinois Board of Nursing, stipulating that his nursing license was subject to discipline as a result of diverting Demoral from his employer for personal consumption.
Probation 01/24/2013 to 01/24/2017

Brandon, Elizabeth Ann
Harrisburg, MO
Registered Nurse 081065
On June 6, 2012, Licensee submitted to a random urine drug screening test given by her employer. The test was positive for marijuana.
Probation 12/14/2012 to 12/14/2017

Henry, Jerry N.
Saint Louis, MO
Registered Nurse 095804
Licensee failed to contact NTS on two occasions, failed to inform his employer about his probation, failed to turn in two employer evaluations or statements of unemployment by the documentation due dates, and failed to complete continuing education classes by the due date.
Probation 01/15/2013 to 09/03/2015

Coon, Rosemary Marie
Trenton, MO
Licensed Practical Nurse 2013005347
On December 5, 1996, Applicant pled guilty to excessive blood alcohol content. On September 6, 2001, Applicant pled guilty to the class D felony of passing a bad check. On September 6, 2001, Applicant pled guilty to the class D felony of passing a bad check in the Circuit Court of Grundy County, Missouri. On March 13, 2002, Applicant pled guilty to the class D felony of passing a bad check. On April 10, 2002, Applicant pled guilty to the class A misdemeanor of attempting to pass a bad check. On July 19, 2001, Applicant pled guilty to the class B misdemeanor of driving while intoxicated. On March 18, 2001, Applicant pled guilty to the class D felony of passing a bad check. On July 20, 2004, Applicant pled guilty to driving while intoxicated. She was referred to drug court, post plea, on September 16, 2004 and successfully completed the program. On September 11, 2003, Applicant pled guilty to the class D felony of driving while intoxicated.
Probation 02/19/2013 to 02/19/2016

Brummett, Patrick Norman
Belton, MO
Registered Nurse 2005021020
On March 20, 2012, Licensee was observed by a security camera entering a restroom and later leaving the same restroom with his arm in a position as "if he had just given blood." A used syringe labeled "Fentanyl," an alcohol wipe, a bloody cotton ball and a needle cap were later found in the restroom. Licensee admitted to withdrawing Fentanyl and injecting it into himself. Licensee admitted he diverted the Fentanyl and admitted that he had diverted Fentanyl he obtained at the hospital over the previous few months at various times.
Probation 02/13/2013 to 02/13/2018

Probation continued on page 17

Probation continued from page 16

Kesler, MaryBeth Leigh
Peculiar, MO
Registered Nurse 2009017898
On July 2, 2010 Licensee submitted to a urine drug screen. The drug screen was positive for morphine and hydromorphone.
Probation 01/02/2013 to 01/02/2016

Hawkins, Richard H.
Saint Louis, MO
Licensed Practical Nurse 2000158980
According to his official time card, Licensee did not work on July 17, 24, and 27, 2011. However, Licensee signed resident P.H.'s Treatment Administration Records (TAR) for July 17, 24, and 27, 2011, stating that he had performed the prescribed treatments including wound care for resident P.H.
Probation 01/01/2013 to 01/01/2015

Rose, Karen Renee
Saint Peters, MO
Licensed Practical Nurse 2000167161
Count I
On July 22, 2010, the Director of Nursing made copies of a resident's narcotic sheets. The resident's narcotic sheet showed her last dose of Vicodin was signed out on July 19, 2010. The next day, July 23, 2010, when the Director of Nursing checked the narcotic sheet for resident, it showed that Licensee had signed out doses from three previous dates (July 20, 21 and 22, 2010). Licensee signed these doses out at 8:00 p.m. when her shift did not start until 11:00 p.m. When Licensee was confronted about this issue and asked to submit to a drug screen, she turned in her badge and walked out.
COUNT II
On August 21, 2010, Licensee was found "blue, drooling and lifeless" outside the main entrance. The Director of Nursing called 911 and paramedics took Licensee to the hospital where she was admitted. Licensee's drug screen came back positive for amphetamines, methamphetamines, methadone, opiates and cannabinoids.
COUNT III
On November 10, 2010, a card of 15 Vicodin was found missing. Licensee had recorded that the card was completed, but had failed to fill out a Controlled Substance Log (CSL) or document the administration of medication in the Medication Administration Record (MAR). On November 15, 2010, Licensee again recorded that a card of 15 Vicodin was completed, but failed to fill out a CSL or document administration in a MAR. When confronted about the discrepancies in the administration and documentation of Vicodin, Licensee admitted that she had taken the Vicodin and that she had a substance abuse problem.
Probation 12/18/2012 to 12/18/2017

Hamilton, James Lee
Kirksville, MO
Licensed Practical Nurse 2006026920
On May 7, 2011 Licensee took a red permanent marker and drew horns on a resident's forehead. Licensee removed the red ink with an alcohol pad; however, residue remained during the next day.
Probation 02/07/2013 to 02/07/2014

Warren, Shannon
Caruthersville, MO
Registered Nurse 138963
Effective on October 10, 2011, Licensee agreed to a voluntary surrender of her Tennessee RN license to the Tennessee Board of Nursing. The Agreed Order found that licensee admitted that she had diverted narcotics from her workplace, was impaired at her workplace, and tested positive for Fentanyl.
Probation 01/18/2013 to 01/18/2018

Heberlie-Whistler, Jeannie M.
Perryville, MO
Registered Nurse 105559
On October 30, 2007, Licensee was counseled on the issue of behavior contributing to a non-therapeutic and tense work environment and inability to focus and perform tasks. On December 11, 2008, Licensee received a counseling with the issues identified as documentation. On June 29, 2011, Licensee was placed on a performance improvement plan. The issues identified were behavior contributing to a non-therapeutic, disruptive, and potentially unsafe work environment and overall questionable ability to provide safe and competent patient care. Licensee was counseled on her use of restraints. The last five out of seven occurrences of restraint use had been initiated by Licensee. Witnesses state that Licensee's behavior contributed or provoked the patient behaviors to escalate to the use of restraints. A medication error occurred when a patient order was for Diazepam 5mg every six hours and in acknowledging the order Licensee did not note that the wrong dose of 10mg was on the EMAR. The patient received the wrong dose for two days (9 doses). Licensee noted off orders for a patient and it was discovered that the PRN Mylanta, Milk of Magnesia, and Tylenol from the admission pre-printed orders was left off the EMAR. On August 11, 2011, a physician order was written to increase a patient's vasotec from 10 mg to 20 mg. Licensee did not enter the new order into the electronic medication administration record. On September 23, 2011 a patient requested a sleep aide. Licensee obtained the PRN dose of Ambien. The Ambien package would not scan. Licensee asked the patient to try to sleep without the medication. On October 13, 2011, Licensee administered scheduled medications to two patients. Licensee did not chart that she administered the medications at the scheduled times, but documented the

PROBATION Continued....

medications as unscheduled doses. On November 15, 2011, Licensee was placed on a Performance Improvement Plan for concerns related to accurate medication administration and ability to provide safe and competent patient care. On December 16, 2011, Licensee wrote a telephone order for Zyprexa Zidus 5 mg PO at HS. The patient had an order for Zyprexa 10 mg PO at HS. Licensee did not discontinue the Zyprexa 10 mg. The physician had instructed Licensee to discontinue the Zyprexa 10 mg when he gave the telephone order.
Probation 02/21/2013 to 02/21/2016

Nolan, Jennifer A.
Florissant, MO
Registered Nurse 128919
On January 30, 2012 Licensee removed six vials of Fentanyl for a patient who was not assigned to her. Licensee did not document the administration or waste of the Fentanyl. The facility requested a drug screen of Licensee. The drug screen was positive for Fentanyl and Marijuana. A review of the medical records revealed that Licensee had removed approximately forty vials of Fentanyl from a Pyxis at the Hospital from December 31, 2011 through January 30, 2012, for which there was no documentation of administration or waste. A review of medical records revealed that Licensee had removed 142 Fentanyl vials from a Pyxis from October 1, 2011 through January 30, 2012, for which there was no documentation of administration or waste.
Probation 12/25/2012 to 12/25/2017

PROBATION Continued....

Davis, Jeffrey Scott
East Prairie, MO
Registered Nurse 2011003231
Respondent failed to call the Board's third-party administrator on several dates when required to do so. He also tested positive for alcohol on another date. He also did not provide a sample on another date when so prompted to do so. He also did not timely file an employer evaluation as required by the terms of his probation.
Probation 12/27/2012 to 01/28/2015

McDonald, Kerry W.
Saint Charles, MO
Licensed Practical Nurse 058747
On April 19, 2011, Licensee pled guilty to the Class A misdemeanor of assault of a law enforcement officer.
Probation 01/01/2013 to 01/01/2014

Martin, Jason Wayne
Ozark, MO
Registered Nurse 2002002333
Respondent's license is subject to discipline for testing positive for a controlled substance in a for-cause drug screen given by his employer. He is also subject to discipline for being disciplined by the state of New Jersey for conduct that, had it occurred in Missouri, would have been subject to discipline.
Probation 12/27/2012 to 12/27/2017

Probation continued on page 18

Probation continued from page 17

Williams, Jerrica Joyce
Kansas City, MO
Licensed Practical Nurse 2006036039
Licensee submitted to a pre-employment drug screen on July 13, 2010. Licensee's drug screen was positive for Tetrahydrocannabinol ("THC," or Marijuana).
Probation 12/18/2012 to 12/18/2017

Johnston, Stacy Nicole
Florissant, MO
Licensed Practical Nurse 2007016299
Respondent's license is subject to discipline for diversion of controlled substances to herself and for testing positive for a controlled substance in a for-cause drug screen given by her employer.
Probation 01/11/2013 to 01/11/2018

Tucci, Susan Elizabeth
Fenton, MO
Registered Nurse 2007034762
Respondent's license is subject to discipline for numerous errors at three different facilities, administering controlled substances to herself and discrepancies in medication administration.
Probation 12/27/2012 to 12/27/2016

Henderson, Annette Alverda
Saint Joseph, MO
Licensed Practical Nurse 2000169811
On July 23, 2010, Licensee was informed that her services were not needed for the weekend of July 24 and July 25, 2010. On July 27, 2010, Licensee turned in paperwork to her supervisors indicating that she had worked the weekend of July 24 and July 25, 2010 and provided care to a home health client. The paperwork turned in included flow sheets, pediatric physical assessments, and nursing notes on client/patient. Licensee admits that she did not work the weekend of July 24 and July 25, 2010.
Probation 01/01/2013 to 01/02/2013

Sanchez, Jenna Marie
Saint Peters, MO
Registered Nurse 2010006603
Respondent's license is subject to discipline for diversion of controlled substances to herself and discrepancies in medication administration.
Probation 01/11/2013 to 01/11/2018

McDowell, Rebecca S.
Blue Springs, MO
Licensed Practical Nurse 053835
Patient suffered from multiple terminal conditions including multiple sclerosis, immunocompromise and neurogenic bowel and bladder. On February 1, 2009, during Respondent's shift, patient had difficulty breathing and the patient's oxygen saturation levels fell to unsafe levels. At the suggestion of her supervisor, Respondent started patient M.P. on oxygen. Respondent failed to document that she had started patient on oxygen. Respondent failed to document the change in the patient's condition that led to the administration of oxygen. Respondent failed to advise the patient's physician of the patient's change of condition or that she had started the patient on oxygen. Later that night, the patient was found dead. The physician had no knowledge of these events until after the patient died.
Probation 12/18/2012 to 12/18/2014

Rhoads, Jannice L.
Excello, MO
Registered Nurse 135156
On September 21, 2011, at the Home, resident fell at 2330. Licensee documented that resident had a 2 cm split above his upper lip. Her chart documentation showed the following words: "et 1 cm split. 10 cm X 8 cm reddish purple raised area on (L) forehead." Licensee notified the physician on-call for

PROBATION Continued....

the home of the fall at approximately 2340. However, licensee failed to inform the physician that resident's Protime (PT) time, as previously measured on August 22, 2011 was 29.5 seconds. Licensee also failed to inform the physician that resident was on Aspirin 81 mg PO daily; Plavix 75 mg PO daily; and Coumadin 10 mg daily. All of these medications are essentially medications that are meant to lengthen the time it takes for a person's blood plasma to clot. Licensee stated that she performed a neuro-check on resident after the fall and it was documented that one neuro-check on resident was performed by licensee at approximately 2350-2355. However, licensee did not document what was meant by "neuro-check" and it was not documented what this "neuro check" consisted of. Licensee did not document any further neuro checks on resident. Licensee did not document anything at all in resident's chart between 0150 and 0550 on September 22, 2011. Resident was found unresponsive at approximately 0550 on September 22, 2011, was diagnosed with a subdural hematoma, and later expired at a hospital.
Probation 01/02/2013 to 01/03/2013

Ebbers, Anthony Hubert
Kansas City, MO
Registered Nurse 2000162899
A chart audit was conducted on Licensee's charts at the Hospital. The audit revealed charting errors including discrepancies between medications withdrawn from the Pyxis and the medication documented as administered to patients. Licensee admitted to improperly dispensing narcotics.
Probation 12/18/2012 to 12/18/2017

Smith, Angie
Saint James, MO
Registered Nurse 153074
COUNT I
On February 21, 2007, February 22, 2007, and March 1, 2007, Licensee's service logs had overlapping times resulting in documentation errors on service delivery logs.
COUNT II
Licensee admitted to use of Marijuana. Licensee admitted that she smoked Marijuana with her daughter, who was fourteen years old at the time.
COUNT III
On January 7, 2011, Licensee voluntarily submitted to a pre-employment drug screen. The drug screen was positive for Marijuana.
Probation 12/19/2012 to 12/19/2017

Lang, Carol Ann
Cape Girardeau, MO
Registered Nurse 2009026006
On September 21, 2011 Licensee administered Glipizide to a patient when the patient's blood sugar was a 41. On December 15, 2011 Licensee administered Nebivolol to a patient whose blood pressure was 95/73. The parameters for administration of Nebivolol are to hold administration when the patient's blood pressure is less than 110. On May 23, 2012, Licensee signed a consent for colonoscopy form indicating that the patient's son, who had power of attorney for the patient, had given consent for the procedure when Licensee had not spoken to the son about the procedure.
Probation 01/24/2013 to 01/24/2015

Lawless, Shelly R.
Glencoe, MO
Licensed Practical Nurse 048130
Licensee diverted Vicodin and Percocet for her personal consumption.
Probation 01/24/2013 to 01/24/2016

Wirtz, Travis M.
Kansas City, MO
Registered Nurse 2008007483
On March 14, 2012, Licensee withdrew two tablets of Oxycodone at 2156. Licensee did not document the

PROBATION Continued....

administration or waste of the Oxycodone. On March 2, 2012 at 1945, Licensee removed two tablets of Valium. Licensee did not document the administration or waste of the Valium. On February 23, 2012, Licensee withdrew two tablets of Valium at 2239. Licensee did not document the administration or waste of the Valium. On February 23, 2012, at 2224, Licensee removed Morphine 4mg. Licensee documented the administration of this 4 mg of Morphine at 2200, which is an impossibility. On February 23, 2012, at 2224, Licensee removed 5mg of Valium. Licensee did not document the administration or waste of the Valium. On February 22, 2012, Licensee removed two tablets of Norco. Licensee only documented the administration of one tablet of Norco. Licensee did not document the administration or waste of the tablet of Norco. On February 23, 2012, Licensee removed Demerol at 239. Licensee did not document the administration or waste of the Demerol.
Probation 01/18/2013 to 01/18/2018

Wintjen, Amanda Nicole
Hannibal, MO
Licensed Practical Nurse 2008029827
From January 26, 2012 through February 15, 2012 patient AR was in the hospital. Licensee turned in time sheets but was not at the client's home.
Probation 01/18/2013 to 01/18/2016

Eager, Marlene E.
Lone Jack, MO
Registered Nurse 155510
On August 10, 2011 a Certified Nursing Assistant (CNA) was pulled over in a traffic stop and a bottle of promethazine with codeine belonging to a resident was found in her car. The Disposal or Return of Medication form for that bottle of promethazine with codeine was dated July 27, 2011 and it indicated that 70 ml of the medication was destroyed at the facility. Licensee signed the form, indicating she wasted or witnessed the waste of the medication. Licensee allowed the CNA to waste the bottle of promethazine with codeine.
Probation 01/04/2013 to 01/04/2014

Turner, Karen L.
Doniphan, MO
Registered Nurse 116965
Licensee received from the Center a "Final written warning" on October 5, 2011, for failure to change an abdominal wound dressing on patient X, who she was responsible for, for two consecutive shifts. Licensee did not change the dressing or document that the wound was draining and merely documented that she "left the dressing for the physician to see." Patient X complained that the dressing was not changed, and it was noted by the Center that patient X's bed linens were saturated from the wound drainage. Patient X had also only a few hours before licensee assumed care for him, undergone surgery. Dr. S. later expressed concern that licensee did not call him in reference to patient X because with the large amount of drainage present, he would have liked a call in the middle of the night so he could further assess or diagnose patient X in reference to the drainage. In a second incident at the Center on December 21, 2011 for patient Y that licensee was responsible for, also with a wound dressing that was completely saturated, licensee merely charted "right AKA" (right above the knee amputation); and did not document anything about Y's dressing. Licensee was asked by Center staff to change the dressing more than once because patient Y was having multiple stools, which could contaminate patient Y's wound. Licensee did not change the dressing for her entire shift. Licensee also did not record patient Y's multiple stools or a description of the wound or dressing on the right stump. At the end of the licensee's shift, the next shift found patient Y with a saturated dressing which was hanging off the right stump and Y's bed was wet.
Probation 01/18/2013 to 01/19/2013

Culp, Linda M.
Joplin, MO
Registered Nurse 127180
Licensee falsified company records in patient charts and also for improper removals from a pyxis machine. Licensee did not document either the administration or waste of the Morphine she withdrew for patients on approximately 26 different days.
Probation 01/01/2013 to 01/01/2016

Probation continued on page 19

Probation continued from page 18

Albertson, Bobby Leonard
Lake Saint Louis, MO
Registered Nurse 2006006116
Respondent has failed to call in to NTS on six (6) different days. Further, on July 25, 2012, Respondent called NTS and was advised that he had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. The Board did not receive completion of any completed continuing education hours by the documentation due date.
Probation 01/09/2013 to 02/23/2014

Johnston, Chelsea Marie
Springfield, MO
Registered Nurse 2013002075
Respondent was licensed as a Registered Professional Nurse in New Jersey and she voluntarily surrendered her nursing license in a Order of Voluntary Surrender as a result of diverting Percocet from her employer for personal consumption on November 16, 2009. Respondent then enrolled in the New Jersey Recovery and Monitoring Program (RAMP). Respondent's license was then reinstated on July 30, 2010 under specified terms and conditions. Due to Respondent not being physically well, the peer counselor did not sign off for Respondent to return to work. Respondent ceased complying with the Order of Reinstatement; hence, New Jersey issued a Final Order of Discipline on August 22, 2011, suspending her license due to non-compliance with the terms and conditions of the Order of Reinstatement.
Probation 01/23/2013 to 01/23/2018

Coy, Laura Michelle
Cameron, MO
Licensed Practical Nurse 2006030429
On September 21, 2010, Licensee removed narcotics at the time her shift was ending on four patients, causing suspicion and instigating an internal investigation. On September 21, 2010, Licensee dispensed narcotics to patients not assigned to her and without the knowledge of the nurses assigned to the patients. Licensee did not document pain levels on the flow sheet for the patients she dispensed as needed (PRN) narcotics to Licensee did not document the administration of the narcotics on the medication administration record for patients. Licensee removed narcotics for patients from the medDISPENSE without a witness.
Probation 12/01/2012 to 12/01/2015

Driver, Gennifer Nicole
Cape Girardeau, MO
Licensed Practical Nurse 2000173247
On February 22, 2012, Licensee called in a prescription for Hydrocodone/APAP 10/325 number 25 for a co-worker without a physician order. On February 22, 2012 Licensee called in a prescription for triamcinolone and bactroban for her daughter without a physician order.
Probation 01/24/2013 to 01/24/2016

Collins, Gloria
Versailles, MO
Licensed Practical Nurse 2000163736
On or about June 7, 2011, Licensee took her daughter to the emergency room at the hospital for what she believed was an ear infection. Licensee was advised by the Emergency Room nurse that her daughter had third degree burns on her body from a hot liquid being poured or dumped on her. The physicians at the hospital stated that the daughter had burns over 11% of her body and several of the areas were infected. The hospital had to perform skin graft surgery on Licensee's daughter to repair

PROBATION Continued....

damaged skin. Licensee's daughter went from June 2, 2011, until June 7, 2011, without proper medical treatment for life threatening injuries. On April 12, 2012, Licensee pled guilty to Endangering the Welfare of a Child- 1st Degree.
Probation 02/21/2013 to 08/21/2017

Stewart, Tessa Layne
Kansas City, MO
Registered Nurse 2013004777
In January, 2012, Applicant consumed alcohol and then overdosed on Xanax and Hydrocodone that she found in a friend's closet.
Probation 02/14/2013 to 02/14/2018

Timmerman, Scott
Villa Ridge, MO
Registered Nurse 110143
Patient had an order for Pantoprazole one daily for GERD. Pantoprazole medications were in a "bubble pack." Licensee documented that he administered the medication to patient on January 27 and 28, 2012. The bubble pack did not change in appearance from one day to the next. Patient had a sliding scale insulin (SSI) order for HS at 2200. Patient had a sliding scale insulin order for with meals at 0700; 1130; and 1630. Licensee used the wrong SSI medication for the 2200 distribution on January 10, 2012 through January 12, 2012; January 14, 2012 through January 20, 2012; and, January 23, 2012 through January 26, 2012. Licensee received an order to change the time that Plavix was administered for a patient. The time was to be changed from evening administration to morning administration. Licensee discontinued the evening dose but did not transcribe the new time of administration to the morning. The patient did not receive Plavix from January 13 through 18, 2012.
Probation 02/13/2013 to 02/13/2015

Dalton, Tammy Denise
Curryville, MO
Registered Nurse 2003012801
On May 11, 2012, Licensee was tasked with destroying medications. Licensee asked a charge nurse to assist in destroying the medications. The charge nurse was called away, and Licensee was witnessed pouring a sticky red liquid into an Advil bottle and putting it into her purse.
Probation 01/24/2013 to 01/24/2018

Abt, Heather Renee
Sainte Genevieve, MO
Registered Nurse 2012037675
Licensee practiced as a graduate nurse from September 25, 2011 to November 6, 2011 without having passed her NCLEX-RN.
Probation 01/11/2013 to 01/11/2015

REVOCATION

Jones, Jessica F.
Mexico, MO
Licensed Practical Nurse 057186
On January 22, 2008, Respondent called a prescription for Vicodin in to a pharmacy. Respondent identified herself under the alias "Laura" and falsely provided the name of a patient as

REVOCATION Continued....

the recipient of the Vicodin. Respondent falsely provided the name of a physician as the prescribing physician.
Revoked 12/17/2012

Dowling, Liza Ann
Saint Charles, MO
Licensed Practical Nurse 2006010201
Respondent was required to obtain specified continuing education hours and have the certificate of completion for all hours submitted to the Board by September 28, 2012. Respondent never submitted to the Board proof of any completed hours.
Revoked 12/20/2012

Spillman, Kirsten D.
Bonita Springs, FL
Registered Nurse 126140
On May 20, 2008, Respondent arrived for her shift at approximately 7:50 p.m.
A review of Respondent's use of the Diebold system showed multiple discrepancies involving three patients. In regards to the first patient, Respondent removed multiple doses of Zyloprim, Norvasc and Lipitor at times when only a single dose was ordered to be administered. In regards to the second patient, the patient was not assigned to Respondent; however, Respondent removed Valium, Lovenox, Cozaar, Compazine, Zocor, Betapacea and Flomax for the patient. It was also discovered that Lovenox had been discontinued for this patient. In regards to the third patient, Respondent was not assigned to the patient; however, Respondent removed Nexium for the patient even though the nurse assigned to care for the patient documented the administration of Nexium to the patient prior to Respondent's removal of the medication. The three other patients assigned to Respondent on May 20, 2008, had no Diebold activity for her shift, indicating that Respondent did not remove any of the medications ordered for those patients. Respondent could not give report because she did not seem to know anything about her assigned patients and she was "walking in circles" while trying to give report. On February 27, 2008, the father of a patient that Respondent was caring for requested a different nurse, as Respondent appeared "drunk or on drugs" and had tripped over his wife. It was also stated that Respondent had fallen asleep several times while charting and repeatedly gave the same directions for discharge. Respondent was later assigned to care for a patient who had ankle surgery on that date. Respondent did not complete any charting for the patient and sat at the nurse's desk rather than provide care to the patient. On another patient, Respondent pulled ten milligrams of Morphine. Respondent then documented that she administered eight milligrams of Morphine and wasted seven milligrams of Morphine from the same vial. The patient who received the dose of Morphine was a minor child who could not have received more than one milligram of Morphine.
Revoked 12/17/2012

Revocation continued on page 20

Revocation continued from page 19

Schall, Christine A.
Columbia, IL
Licensed Practical Nurse 049370
Cause exists to discipline the nursing license of Christine Schall for falling asleep while on duty as a licensed practical nurse and for discipline imposed against her nursing license in the State of Illinois.
Revoked 12/18/2012

Jordan, Christopher J.
Jefferson City, MO
Registered Nurse 082088
The Administrative Hearing Commission found Christopher Jordan's nursing license is subject to discipline because he diverted controlled substances from his place of employment, and because he pled guilty to a crime reasonably related to his profession having an essential element of dishonesty and that involved moral turpitude.
Revoked 01/15/2013

Eastham, Janet L.
El Dorado Springs, MO
Registered Nurse 148684
Cause exists to discipline the nursing license of Janet Eastham for failing to properly chart the administration of medications to patients, failing to follow established protocols for patient care, and testing positive for a controlled substance for which she did not have a prescription.
Revoked 12/18/2012

Brady, Colleen C.
Fulton, MO
Licensed Practical Nurse 024390
Cause exists to discipline the nursing license of Colleen Brady for testing positive for alcohol while at work.
Revoked 12/18/2012

Holmes, Marta L.
Columbia, MO
Registered Nurse 100101
Respondent had responsibility for patients in the Symptom Evaluation Unit (SEU), a walk-in urgent care unit for Oncology patients as well as other patients in the facility. On June 5, 2008, Respondent received a verbal warning for late documentation, breach of patient confidentiality, medication administration, delay in initiation of chemotherapy, commitment to co-workers and patients, and not taking vital signs on six of eight patients. Examples of delayed or incomplete documentation by the Respondent including her failure to timely, if ever, record vital signs include patient records from May 24, 2008, May 25, 2008, May 31, 2008, and June 1, 2008. On June 5, 2008, Respondent was counseled regarding an incident where a patient of hers was seen in the SEU early in the day then returned to the emergency room (ER) with chest pain but could not be admitted into the ER for treatment because Respondent still had the patient in the system in SEU. On June 5, 2008, Respondent acknowledged and understood the areas that required her improvement. A plan was made to help her in the SEU and on the floor. On August 2, 2008, Respondent was assigned to administer a scheduled 1700 dose of chemotherapy to a patient. The dose had not been administered at 1700, requiring another nurse to administer the dose. On August 5, 2008, Respondent was assigned to administer a scheduled 1700 dose of chemotherapy to a patient. The dose had not been administered at 1800, requiring another nurse to administer the dose. On November 8, 2008, an order was written at 1025 to transfuse two units of packed red blood cells and then discharge the patient to home. The order was noted by Respondent at 1145. The packed red blood cells were ready for administration at 1235. Respondent did not begin the administration of the packed red blood cells until 1415. The first unit was completed at 1645 and the second unit was not hung until 1715. Failing to administer the packed red blood cells for the patient in a timely manner caused delay (discharge and treatment) for the patient and resulted in the oncoming nurse to finish Respondent's work. On November 15, 2008, an order was written to type and cross and transfuse two units of packed red blood cells to patient. Respondent noted the order at 1015. Respondent did not hang the first unit until 1330. The first unit was completed at 1630 and the second unit was not hung until 1705. Failing to administer the packed red blood cells for the patients, in a timely manner caused delays for the patients and resulted in the oncoming nurse to finish Respondent's work. On December 21, 2008, Respondent discharged a patient from room 515 before 1500. Respondent removed a controlled analgesic (PCA) pump from the patient. Respondent then placed the PCA in the hallway where it remained until 1900. The PCA contained 39cc of Morphine. On December 27, 2008, a patient was admitted to SEU for lab tests to determine if he would receive his scheduled chemotherapy that day. Respondent failed to assist the patient or have labs drawn for forty-five (45) minutes, requiring another nurse to draw labs. On March 5, 2009, Respondent received a written warning for late documentation, breach of patient confidentiality, timely administration of blood product, time management, and commitment to co-workers and patients. On March 5, 2009, Respondent acknowledged and understood the areas that required her improvement. On July 28, 2009, Respondent was assigned to provide care to a patient but did not document on the patient. The patient was also not noted in the patient log. On October 17, 2009, a Pneumococcal Vaccine was scheduled per standing hospital protocol as a physician's order. It was to be administered at 0800 to a patient. The medication was not charted as given by Respondent.
Revoked 12/17/2012

REVOCATION Continued....

Feltrop, Sherry L.
Jamestown, MO
Registered Nurse 093729
On January 14, 2009, Respondent was convicted of 'Driving While Intoxicated - Drug Intoxication.'
Revoked 12/18/2012

Pribble, Shelley Ann
Bonne Terre, MO
Licensed Practical Nurse 2005036127
On February 26, 2010, Respondent pled guilty to Forgery. On July 7, 2010, Respondent tested positive for heroin, a controlled substance. Respondent did not have a prescription for heroin.
Revoked 12/18/2012

Muse, Sheila Lynn
Steele, MO
Licensed Practical Nurse 2005032631
On April 10, 13 and April 14, 2009, while on duty, Respondent diverted hydrocodone.
Revoked 12/17/2012

Surber, Shannah Marie
Blue Springs, MO
Licensed Practical Nurse 2005003293
Cause exists to discipline the nursing license of Shanna Surber for pleading guilty Fraudulently Attempting to Obtain a Controlled and for pleading guilty to Possession of a Controlled Substance.
Revoked 01/02/2013

DeVore, Katya
Sorento, IL
Registered Nurse 2006019130
Respondent was required to contract and enroll with the Board's third party administrator (TPA), currently National Toxicology Specialists, Inc. (NTS), to schedule random witnessed screening for alcohol and other drugs of abuse within twenty (20) working days of the effective date of the Agreement, or by November 1, 2012. Respondent has not completed the contract or enrollment process with National Toxicology Specialists, (NTS). Respondent was required to submit a chemical dependency evaluation to the Board by November 15, 2012. The Board has not received an evaluation.
Revoked 12/27/2012

Blanks, Iris B.
Saint Louis, MO
Registered Nurse 152306
On May 25, 2006, Respondent refused to administer Thorazine to a patient as required by physician's order. On November 15, 2006, Respondent received a written reprimand for failure to follow facility policy regarding the process for physician notification of a special procedure. On February 5, 2007, Respondent received a written reprimand for administering medication without a physician's order and signing off on a medication order change without making the appropriate changes to medication dosage on the medication administration record. On July 11, 2008, Respondent refused to administer Zyprexa to a patient as required by physician's order.
Revoked 12/17/2012

Akers, Lisa C.
New Braunfels, TX
Registered Nurse 150879
On January 24, 2011, a patient that was seen by Respondent was prescribed Augmentin and Tessalon Perles. Neither medication was listed in the patient's medication list. This patient returned for a visit on February 4, 2011 and was given another prescription. On January 26, 2011, a husband and wife were seen by Respondent and were prescribed antibiotics from the dispensary system. Neither prescription had dosing instructions on the bottle, and the husband's bottle had the wrong last name on it. On February 4, 2011, staff gave Respondent a detailed note to create a work excuse on a certain patient and the note Respondent created was for the wrong patient. On February 9, 2011, Respondent failed to address a faxed medication refill request for a Pharmacy from February 3, 2011 and February 9, 2011. On the evening of February 10, 2011, Respondent saw three patients. On February 10, 2011, Respondent saw a patient but failed to order and call in two medications for the patient at the Pharmacy. On February 11, 2011, there was a discrepancy with the in-house inventory. Upon further investigation it was determined that on January 24, 2011 Respondent entered a prescription of antibiotics that she dispensed to a patient for bronchitis and otitis media. Respondent also dispensed a course of Augmentin from the in-house inventory but failed to update the easyscript website. On February 14, 2011, Respondent saw a child and ordered Omnicef through the Electronic Medical Records (EMR), which automatically documents in the patient's office note. Later in the evening on February 14, 2011, Respondent typed her plan which stated the child was given Augmentin. Staff reported that Respondent had the following issues in one day:
a. At 3:00 p.m., Respondent saw her first patient for the day. The child came in with a temperature of 104.2. Respondent failed to assess the patient, but instead proceeded to have a conversation with a drug representative; b. Staff informed Respondent that patient, R.S., needed a prescription refill. Respondent failed to call in the prescription for the patient; c. A patient was sent to the hospital for a bone density which Respondent diagnosed as a hyperthyroidism. Diagnosis had to be amended by staff; and, d. Respondent threw away papers with a patient's name on it in a regular trash instead of shredding them.
Patient was seen by Respondent for the second time for a fever. Respondent failed to call in medication to the pharmacy and failed to add the medication to the patient's medication list.
Revoked 12/17/2012

Dinwiddie, Tracy Lee
Blue Springs, MO
Registered Nurse 2004026161
Respondent worked in the operating room as a circulating RN during August and September, 2007. The employer conducted five separate counts for Darvocet pills which showed a count of 19 pills in the drawer since August 27, 2007. On September 10, 2007, a count was done showing only three Darvocet pills in the drawer. A review of the Acudose Rx Station Events Report revealed that Respondent's name was the only name listed on the report as having entered the drawer. The report indicated that Respondent had entered the drawer three times over the preceding weekend to obtain pills for two different patients; however, the patients that were listed as having received the drugs were neither in the OR nor in the PACU at the time of the timed entry on the printout. On September 8, 2007, Respondent accessed the Acudose machine and withdrew Darvocet at 10:29 a.m. for a patient. The patient did not have a physician order for Darvocet. On September 8, 2007, Respondent accessed the Acudose machine and withdrew Darvocet at 14:15 p.m. for a different patient. That patient also did not have a physician order for Darvocet. On September 9, 2007, Respondent accessed the Acudose machine and withdrew Darvocet at 14:13 p.m. for a patient. The patient did not have a physician order for Darvocet and the patient left the PACU at 14:05. Respondent did not assist with the care of the above-referenced patients while they were in the PACU.
Revoked 12/17/2012

Steinert, Jacqueline L.
Springfield, MO
Registered Nurse 133175
Respondent's license is subject to discipline for not complying with the terms of her probation by not contracting with a Board-approved random drug and alcohol screening service as required, not timely filing employer evaluations and not filing proof of a chemical dependency evaluation as required.
Revoked 12/27/2012

Weber, Pamela J.
Holts Summit, MO
Registered Nurse 2000144241
On January 20, 2010, Respondent received counseling for failing to complete new admissions orders or failing to have the admissions correct. On March 18, 2010, Respondent hung Vancomycin 1300 mg on a patient instead of the patient's ordered Vancomycin 1500 mg. The Vancomycin 1300 mg was a different patient's prescribed medication. On May 17, 2010, Respondent requested a certified nursing assistant to administer a morphine nebulizer treatment to her patient. Administering a controlled substance, in any form, is outside the scope of practice for a certified nursing assistant.
Revoked 12/17/2012

Daniels, Kurt Kimberly
Phillipsburg, MO
Registered Nurse 2001000060
Respondent's license is subject to discipline for recording that he performed an assessment, which detailed a patient's condition when in fact he did not assess the patient,
Revoked 12/27/2012

Robinson, Gregory J.
Saint Louis, MO
Registered Nurse 137461
Respondent's license is subject to discipline for removing sharps containers from patients rooms and diverting syringes and unused medications to himself.
Revoked 12/27/2012

Evers, Elaine Ann
Lebanon, MO
Licensed Practical Nurse 2001027052
Respondent was convicted of receiving stolen property of $500 or more.
Revoked 12/17/2012

West, Meagan Eva
Creve Coeur, MO
Registered Nurse 2008008557
The AHC found cause to discipline the nursing license of Meagen West for diverting controlled substances at her place of employment.
Revoked 12/17/2012

Daugherty, Jeanette R.
Tecumseh, MO
Licensed Practical Nurse 043454
Cause exists to discipline the nursing license of Jeanette Daugherty for discipline imposed against her nursing license in the State of Arkansas and for failing to properly administer medications to patients as ordered and to properly document in patients' charts.
Revoked 12/20/2012

Revocation continued on page 21

Revocation continued from page 20

Holder, Joyce E.
Cairo, IL
Licensed Practical Nurse 052793
Respondent diverted the controlled substance of Meperidine for herself and pled guilty to the theft/stealing of the Meperidine.
Revoked 12/17/2012

Hardesty, Luanna J.
New Bloomfield, MO
Licensed Practical Nurse 056026
On September 19, 2003, Respondent pled guilty to Assault on Law Enforcement Officer -3rd. On September 19, 2003, Respondent pled guilty to Trespass 1st Degree. On September 19, 2003, Respondent pled guilty to Property Damage 2nd. On November 2, 2006, Respondent pled guilty to Leaving the Scene of a Motor Vehicle Accident. On November 2, 2006, Respondent pled guilty to Resisting/Interfering with Arrest, Detention or Stop. On November 2, 2006, Respondent pled guilty to Operated Vehicle on Hwy Without Valid License -1st or 2nd Offense. On November 13, 2007, Respondent pled guilty to Assault/Attempt Assault on Law Enforcement, a Class C Felony. On November 13, 2007, Respondent pled guilty to Assault/Attempt Assault on Law Enforcement. On November 13, 2007, Respondent pled guilty to Resisting/Interfering with Arrest, Detention, or Stop On February 11, 2009, Respondent pled guilty to Assualt/ Attempt Assault on Law Enforcement. On February 11, 2009, Respondent pled guilty to DWI - Combined Alcohol/Drug Intoxication. On February 11, 2009, Respondent pled guilty to DWI - Alcohol. On September 19, 2003, Respondent pled guilty to two counts of Domestic Assault -3rd Degree -1st/2nd Offense. On February 11, 2009, Respondent pled guilty to four counts of Assault/Attempt Assault on Law Enforcement Officer. On February 11, 2009, Respondent pled guilty to Resisting/ Interfering with Arrest, Detention or Stop. On February 11, 2009, Respondent pled guilty to Property Damage 2nd Degree. On June 11, 2009, Respondent pled guilty to Property Damage 2nd Degree.
Revoked 12/20/2012

Kuehn, Amanda Christine
Saint Louis, MO
Registered Nurse 2000151384
The Administrative Hearing Commission found that Amanda Kuehn's license is subject to discipline because she tested positive for a controlled substance.
Revoked 12/24/2012

Haynes, Amanda Michele
Hayti, MO
Registered Nurse 2007024059
Amanda Whitson-Haynes violated the terms of a Board Order by failing to contact National Toxicology Specialists on four occasions, by submitting a sample with a low creatinine level, by failing to meet with the Board Discipline Administrator as ordered, and by failing to complete continuing education units.
Revoked 12/17/2012

Gunn, Shannon Marie
Belton, MO
Registered Nurse 2001033427
Respondent failed to call in to NTS on eleven different (11) days. On November 4, 2011, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading of 14.0. One of the missed calls was on November 5, 2011, the day after the low creatinine level was submitted as her sample.
Revoked 12/24/2012

Langston, Susanne M.
Columbia, MO
Licensed Practical Nurse 050275
While employed as a nurse, Respondent misappropriated Ativan (Lorazepam) from two residents. Respondent changed a dosage amount by calling a pharmacy and stating it was per a doctor's order, which was false. Respondent also refused to take a drug test after an investigation into the matter, but admitted she would test positive for Ativan. On July 7, 2008, Respondent's name was placed on an Employee Disqualification List for a period of ten (10) years for misappropriation of residents' medications.
Revoked 12/17/2012

Warren, Susan Kathleen
Kirksville, MO
Licensed Practical Nurse 2003028049
On July 30, 2009, Respondent pled guilty to one (1) count of 'Bank Fraud' in the United States District Court for the Eastern District of Missouri.
Revoked 12/17/2012

Cox, Sherry D.
Oregon, MO
Licensed Practical Nurse 029760
Cause exists to discipline the nursing license of Sherry Cox for failing to assess a nonresponsive patient after a suicide attempt and failing to follow the established protocol when handling a nonresponsive patient.
Revoked 12/17/2012

Calhoun, Jaime Lee
Lawson, MO
Licensed Practical Nurse 2003003853
The Administrative Hearing Commission found that Respondent's nursing license is subject to discipline because she impersonated a co-worker and forged the co-worker's signature to receive controlled substances and later diverted these controlled substances. She was also permanently placed on an employee disqualification list.
Revoked 12/20/2012

King, Robert W, Jr
Marshall, MO
Licensed Practical Nurse 2001025337
On June 6, 2007, Respondent's two-year old son, E.K., opened a bag of mortar used for tiling and spread the mortar over the back deck of the home. While Respondent was cleaning E.K, Respondent became angry with the child and slapped E.K. hard enough to leave bruises on the left side of E.K.'s face. E.K.'s bruises were observed to be dark red in color and appeared to be in the shape of a hand and fingers. On August 1, 2007, Respondent pled guilty to assault in the third degree.
Revoked 12/17/2012

Cadwallader, Brandi Lynn
Brumley, MO
Registered Nurse 2006023056
Respondent failed to call in to NTS on five (5) occasions. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of November 12, 2012. The Board did not receive proof of support group attendance by the November 12, 2012, documentation due date.
Revoked 12/19/2012

Miller, Jessica Morgan
Columbia, MO
Licensed Practical Nurse 2003023943
Respondent documented giving medications to residents, but residents did not receive the medications as documented. Respondent was requested to submit to a urine drug screen. She provided a sample, but it was cold and did not register a temperature. She was asked to provide another sample, but said she could not and stated that her urine would be positive for marijuana. On February 19, 2010 and March 9, 2010, Respondent forged the signature of a physician on prescriptions for herself for Percocet. Respondent filled the February 19 prescription. When she presented the March 9 prescription at the same pharmacy, the pharmacist questioned the signature and called the physician. The physician denied writing the prescription and upon further investigation, it was discovered that the physician had not written the prescription.
Revoked 12/17/2012

Duchon, Deborah K.
Saint Louis, MO
Registered Nurse 084772
On February 1, 2010, Respondent was placed on the Department of Mental Health's employee disqualification registry (registry). On March 27, 2009, Respondent transported a patient/client receiving services from the Department of Mental Health (DMH), and was assaulted by the patient/client. Respondent failed to inform her employer that the patient/client assaulted her until six (6) days after the event when confronted by her employer. This placed other employees at the facility in danger as they were unaware of the patient's/client's assaultive nature. Respondent also gave inconsistent stories to the police about what happened.
Revoked 12/19/2012

Rainner, Spring E.
Windsor, MO
Registered Nurse 2001002250
Respondent was required to call a toll free number every day to determine if she was required to submit to a test that day. Respondent failed to call in to NTS on two (2) separate days. Further, on March 12, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of June 8, 2012 and again on September 10, 2012.
Revoked 12/20/2012

Franz, Jeanie P.
Saint Louis, MO
Registered Nurse 081073
On March 11, 2010, Respondent refused to administer pain medication to a patient who was crying out in pain. Respondent failed to notify the patient's physician and did nothing to address the patient's situation. Respondent allowed the patient to cry all night. On March 16, 2010, Respondent refused to administer blood and prepare a patient for a blood transfusion as directed by a physician's order. The 30 minute window to perform this task passed by the time Respondent's inactions were discovered by the charge nurse. On April 9, 2010, Respondent refused to place a patient on a telemetry monitor as directed by a physician's order.
Revoked 12/17/2012

Morrissey, Erin K.
O' Fallon, MO
Registered Nurse 123377
On October 9, 2012, Respondent was required to submit to a test and submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription for amphetamine. On November 7, 2012, Respondent was required to submit to a test and submitted a urine sample for random drug screening to NTS. That sample tested positive for the presence of amphetamine. Respondent did not have a valid prescription for amphetamine.
Revoked 12/20/2012

Harmon, Anita G.
Mineral Point, MO
Licensed Practical Nurse 034370
Respondent did not attend a required meeting on February 15, 2012. Respondent was to submit an employer evaluation from every employer or, if Respondent was unemployed, a statement indicating the periods of unemployment. The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of April 30, 2012, and July 30, 2012. The Board did not receive proof of completion of any continuing education hours by the July 30, 2012 due date.
Revoked 12/20/2012

Hinkle, Mark A.
Jackson, MO
Registered Nurse 135943
Cause exists to discipline the nursing license of Mark Hinkle for pleading guilty to the Class C felony of Voluntary Manslaughter on January 21, 2010 in Lawrence County, Tennessee and for discipline imposed against his nursing license in the States of Arizona and Tennessee.
Revoked 12/18/2012

Mercurio, Rebecca S.
West Plains, MO
Registered Nurse 105045
Cause exists to discipline the nursing license of Rebecca Mercurio for improper charting of medication withdrawal, administration, and wasting and reporting to work with a controlled substance in her system in an amount that would have resulted in impairment.
Revoked 12/17/2012

SUSPENSION/PROBATION

Sanders, Andrea Ruth
Jefferson City, MO
Registered Nurse 2008007343
Suspended 1/4/2013 to 7/4/2013; Probated 7/5/2013 to 7/5/2018
The Center received a phone call on December 29, 2011 from a family member of Licensee concerned about licensee's drug use and that it could be affecting licensee's caring for patients. The Center then requested Licensee take a urine drug screen on that same day. The Center had previously counseled Licensee and warned her that she should not be sleeping on the job as she had been discovered doing so; and also counseled her that she needed to be getting enough rest before coming to work. On December 29, 2011 Licensee submitted to a urine drug screen at the Center. The drug screen was positive for Amphetamine and Methamphetamine.
Suspension 01/04/2013 to 07/04/2013 followed by Probation 7/5/2013 to 7/5/2018

VOLUNTARY SURRENDER

Graham, Patricia K.
Danvers, MA
Registered Nurse 113253
On December 20, 2012, Licensee voluntarily surrendered her Missouri nursing license.
Voluntary Surrender 12/20/2012

Coffee, Dawn Nicole
Sikeston, MO
Licensed Practical Nurse 2000172565
Registered Nurse 2011026193
Licensee was required to completely abstain from the use or consumption of alcohol in any form. On January 23, 2012, Licensee reported to a collection site to provide a sample for drug and alcohol screening. The sample tested positive for EtG, a metabolite of alcohol. The Board revoked her nursing license. Respondent, after initially appealing the revocation of her license, then voluntarily surrendered her license as a result of testing positive for EtG again.
Voluntary Surrender 12/03/2012

LeRoy, Alexa Jane
Liberty, MO
Registered Nurse 2006021289
In December 2009 Licensee admitted to diverting a controlled substance for her personal consumption and on June 24, 2011, Licensee plead guilty to the class C felony of theft of a controlled substance.
Voluntary Surrender 01/25/2013

Harris, Angela Dawn
Elsberry, MO
Licensed Practical Nurse 2006025082
On January 9, 2013, Licensee voluntarily surrendered her Missouri nursing license.
Voluntary Surrender 01/09/2013

Gach, Misty Dawn
Adrian, MO
Registered Nurse 2000146049

Voluntary Surrender continued on page 22

Voluntary Surrender continued from page 21

Licensee was employed at a facility in Missouri. Pursuant to the Facility's policy, Licensee did not have the authority to pick up medication at the pharmacy. On May 9, 2011, Licensee went to the pharmacy and picked up a 30ml bottle of Morphine 100 mg/5ml (the "Medication"). Licensee initialed that she picked up the Medication at the pharmacy. Licensee admitted to the Facility administrator that she went to the pharmacy and picked up the Medication. Licensee never delivered the Medication to the facility or to any of the Facility's patients. An investigation by the Facility discovered that eleven 30ml bottles of Morphine Sulfate distributed from the pharmacy were unaccounted for at the Facility.
Voluntary Surrender 12/10/2012

Sanders, Kevin Paul
Ozark, MO
Registered Nurse 2008027513
On February 14, 2012 Licensee sent approximately sixty (60) text messages to a patient attempting to arrange meetings to provide the patient with narcotics. Licensee admitted, in a letter to the Board, that he was the one sending the text messages.
Voluntary Surrender 12/11/2012

McMillen, Stephanie L.
Columbia, MO
Licensed Practical Nurse 057144
On December 3, 2012, Licensee voluntarily surrendered her Missouri nursing license.
Voluntary Surrender 12/03/2012

VOLUNTARY SURRENDER Continued....

Corso, Tracey L.
Cincinnati, OH
Registered Nurse 2010032008
Licensee's Ohio Registered Professional Nurse license was placed on probation by the Ohio State Board of Nursing on January 20, 2012. The reason(s) licensee's Ohio license was placed on probation was because licensee withdrew narcotics without a physician's order, documented administration of narcotics in violation of physician orders, and failed to account for the administration of narcotics.
Voluntary Surrender 01/01/2013

Mascher, Belinda Lee
Kansas City, MO
Licensed Practical Nurse 2007027179
On May 15, 2012, Licensee telephoned a prescription order for Lortab and Clindamycin to a local pharmacy, utilizing a fictitious patient name and falsely using as authorization the name and BNDD/DEA number of a physician who was the medical director of a family health care clinic for the department. Licensee misrepresented herself by telling the pharmacy staff that she was "one of the clinic nurses" at the department. The pharmacy called the clinic in an attempt to clarify the order. Licensee attempted to pick up the prescription at the pharmacy and was denied. On May 16, 2012, licensee admitted to Department officials that she had falsely called in the prescription and had misrepresented herself to the pharmacy.
Voluntary Surrender 02/28/2013

VOLUNTARY SURRENDER Continued....

Sargent, Carolyn L.
Columbia, MO
Licensed Practical Nurse 054569
Licensee was unsteady as she stood up. Licensee was directed to report to the nurses' station. Instead, Licensee went to the kitchen and waved a chicken leg above her head while saying, "Oh you caught me." Licensee eventually reported to the nurses' station. At the nurses' station, Licensee stood barefoot on her toes and waved her arms in a dancing motion while saying, "The phone is ringing, phone is ringing."
Voluntary Surrender 02/28/2013

Spiegel, Jay Barry
Overland Park, KS
Registered Nurse 2008020351
Licensee's Kansas Registered Professional Nurse license was voluntarily surrendered to the Kansas State Board of Nursing on May 24, 2012. The reason(s) licensee's Kansas license was voluntarily surrendered was because licensee pled guilty in the state of Kansas to three felony counts of sexual exploitation of a child under the age of 18.
Voluntary Surrender 02/13/2013

Braley, Cindy Joanne
Brookfield, MO
Licensed Practical Nurse 2008029483
On April 21, 2010, Licensee entered a guilty plea to Possession of Up to 35 Grams Marijuana. On January 21, 2011, Licensee entered a guilty plea to Possession Of Controlled Substance, a class C felony.
Voluntary Surrender 12/04/2012

NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

_____ ☐ RN ☐ APRN ☐ LPN _____
Missouri License Number Social Security Number

→_____ _____
Signature *(This form must be signed)* Date

NAME AS CURRENTLY IN OUR SYSTEM

_____ _____
Last Name (Printed) First Name (Printed)

NEW INFORMATION

_____
Last Name First Name Middle Name

(_____)_____ (_____)_____ _____
Telephone Number Alternate Number E-mail Address

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ **I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.**

Return SIGNED and completed form by either 1) mail to Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or 2) Fax to 573-751-6745 or 3) scan it and email to nursing@pr.mo.gov